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ESTABLISHED 1878. VOL. 31, No. 5.

MAY, 1893.

NORTH CAROLINA MEDICAL JOURNAL.

Official Organ
Medical Society of North Carolina.

Official Organ
South Carolina Medical Association.

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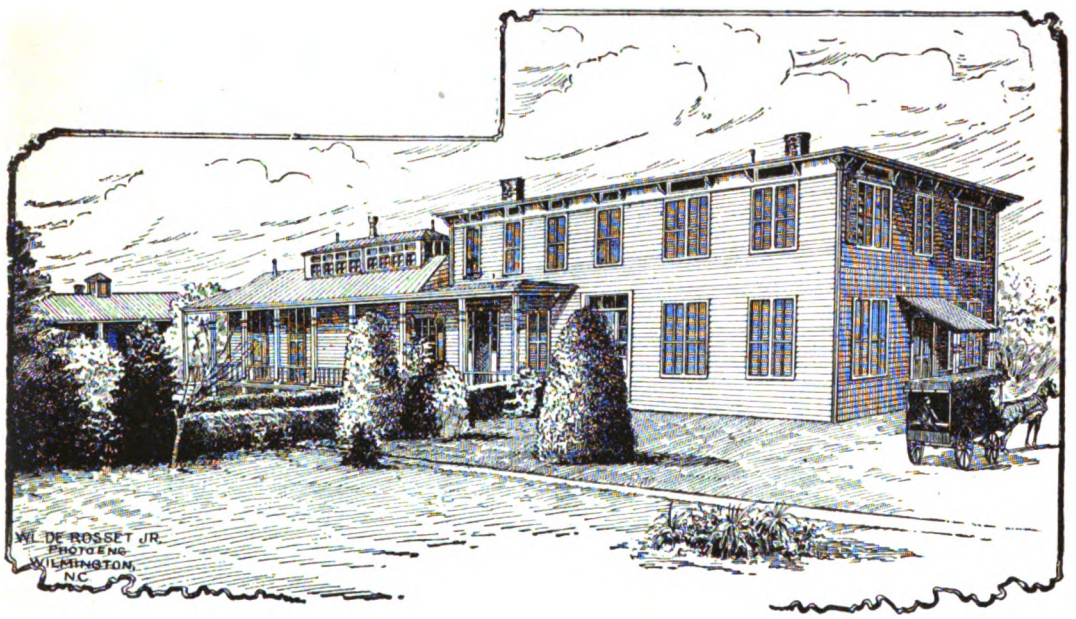

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BY WILLIAM OSLER, M.D.

Delivered in the Amphitheatre of Johns Hopkins Hospital, Baltimore.

[*Reported by D. G. Caldwell, M.D., expressly for this Journal.*]

I.

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The boy has a wide area of cardiac impulse, which extends from the second intercostal space on the right, through the third, fourth, fifth and sixth inter-spaces. The point of maximum intensity is in the sixth inter-space 7 c. m. below nipple and 4 c. m. to left of nipple line. The impulse extends into mid-axillar.

It is difficult to say in this case whether or not the area of heart dulness is movable. On taking a full inspiration the dulness of heart should be largely obliterated, if there be no peri-cardial adhesion.

Auscultation. We find a loud systolic murmur at apex; rumbling echoing murmur in diastole; no murmur at aortic valve; murmur not intense at right of sternum.

As there is no œdema, heart and lungs acting well, I will not give digitalis.

II.

Woman. Has been in hospital before. Was aspirated for ascites. Has syphilitic liver. Has nodes in tibia. In May she had hemiplegia To-day she looks stout, color good, no jaundice.

The abdomen has been enlarging for several weeks and is now much enlarged. Four weeks ago she "had a spell" in

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which she fell at the door; she does not remember having pain. She has an enormous distension of the navel and slight umbilical hernia.

The large size of the abdomen probably is not all due to fluid. In the left side the spleen extends a hand's-breadth below the ribs and is much enlarged. Liver—edge just palpable; on deep inspiration the liver comes down three finger's-breadth; not sore at all; dulness is more marked in the middle region of the abdomen than at the sides.

She has not menstruated for five months; says she is not in a "family way;" well-marked souffle heard in the umbilical region, more marked to the left—thought to be placental souffle; do not feel any fœtal movements; no fœtal heart heard.

Referred to First Assistant Gynecologist, Dr. Robb, to examine for pregnancy.

This woman has, in connection with her syphilitic liver, one feature which has not received the proper amount of attention, namely, enlargement of the spleen. We find this in all forms of cirrhosis.

Hæmorrhage of stomach is very com mon in cirrhosis of liver—often the very first symptom—before any ascites. This point is not often referred to. It is frequently associated with enlarged spleen. But enlarged spleen alone may give hæmorrhage from stomach, as I have seen in case of leukæmia.

III.

Man. Aged 34. Admitted March 15th. Healthy when a boy. Now has jaundice and pain in hepatic region. No fever. Admits drinking slightly for three years. Takes a drink *early in the morning*. Has had epilepsy—attacks mild—has two or three per year. Had an attack of pain followed by jaundice last August. He recovered completely in a few weeks and remained well two months.

He came to this hospital with his second attack. His attacks of pain last from a few hours to several days—has to have morphine. Jaundice continues this time. Stools are clay-colored. Liver slightly enlarged. Sore over epigastric region. Has no itching of skin. Itching is a common symptom of obstructive jaundice. His color does not vary much from day to day.

I can rule out cirrhosis in this case, as jaundice is too deep. Stools are not absolutely clay-colored in cirrhosis.

This case of obstructive jaundice is probably due to impacted gall-stones.

He has no chills or fever; this shows no infection. The cases which have these are due to *Bacillus Coli Communi*.

He is taking 10 ounces of olive oil per day.

I have no faith in it. This forms a concretion which is mistaken for stones. I have given quarts of it and have seen no good results. It has a good impression on the patient.

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NOTES FROM TEN YEARS' SERVICE (4,131 CASES) AT THE PHILADELPHIA DISPENSARY FOR SKIN DISEASES: URTICARIA, ERYTHEMA MULTIFORME, PURPURA AND LICHEN PLANUS.

By Henry W. Stelwagon, M.D., Clinical Professor of Dermatology in the Jefferson Medical College, Dermatologist to the Philadelphia Hospital, etc.

[*Written expressly for this Journal.*]

URTICARIA.

Seventy cases of urticaria came under observation, or a proportion of 1.7 per cent. Of these there were 33 males and 37 females. The ages of patients are shown in the following:

Under 10 years, 8 cases; between 10 and 20 years, 12 cases; between 20 and 30 years, 20 cases; between 30 and 40 years, 11 cases; between 40 and 50 years, 14 cases; between 50 and 60 years, 2 cases; over 60 years, 3 cases.

In as many as 20 cases the disease was more or less chronic, having lasted from a month to several years; this large proportion being not unusual at a special dispensary, where acute cases are not apt to go. In several cases the manifestation was of the papular variety. In one chronic case in which the disease had persisted more or less continuously for six months, sudden and evanescent attacks of swelling of the eyelids, lips and fingers occurred from time to time. Digestive disturbance, uterine irregularities and neurasthenic conditions seemed the most common etiological factors. Internal treatment was based upon a study of the individual case, sodium salicylate, salines, salol, belladonna or its alkaloid atropia, ergot and quinia being most frequently prescribed. Externally relief was often afforded by applications of cooling lotions, such as diluted vinegar, alcohol and water, carbolic acid washes, one to three drachms to the pint, to which were added one ounce of alcohol and a drachm or so of glycerin; by thymol lotions, of one-half to two grains to the ounce, with about the same proportion of alcohol and glycerin to the pint as in the carbolic acid wash; and in some cases by liquor carbonis detergens, with several parts of water; and finally by resorcin lotions, one to four drachms to the pint. Dusting powders were sometimes grateful, more especially when used as a supplementary application to a wash.

ERYTHEMA MULTIFORME.

Forty-three cases of this disease, or a proportion of about 1 per cent., were observed—22 males and 21 females. Of the types of the eruption met with, 15 cases exhibited the papular, 13 the multiform, 2 the annular, 1 the configurate, 4 the herpetic and bullous, and 1 the nodose; in seven cases it was not noted. As regards the site of the eruption, in 8 cases it was upon the back of the hands and forearms; in 6 on the forearms, hands and face; in 3 on the forearms, hands and neck; in 2 on the forearms, hands and trunk; in 7 on the arms and legs, more especially the lower portions; in 2 on the trunk; in 1 on the face and limbs; in 1 on the face; in 10 it was more or less general; and in 3 it was not recorded. The eruption occurring upon the backs of the hands and forearms was almost invariably papular or papulotubercular, and this was even so in generalized cases when the eruption elsewhere was multiform. In two of the bullous cases the eruption was widespread, but that upon the trunk was erythematous and multiform, while that upon the hands and forearms, and to a less degree that upon the face, developed

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rapidly into bullæ; in the third case and fourth bullous cases the eruption in the former was limited to the backs of the hands and forearms, and in the latter mainly to the trunk and upper arms, and was made up of patches of one or several concentric erythemato-vesicular, vesicular and vesiculo-bullous rings—so-called herpes iris. In the nodose case—erythema nodosum—the patient was a boy of 13, and the eruption, consisting of a number of typical erythematous erysipelas-like nodes and swellings, and a few papules and rings, was seated upon the forearms and tibial surfaces.

In a number of cases there were no subjective symptoms to speak of, but this cannot be said of all; itching, it is true, was rarely an urgent symptom, but in some cases, especially in the beginning disease, it was sufficiently annoying to be the subject of complaint. In but a few instances was there any constitutional disturbance, and this consisted of a light febrile action preceding or accompanying the early part of the attack, gastric uneasiness, and, in one or two instances, a slight tendency to rheumatic pain and swelling of one or several of the larger joints; the systemic symptoms were most marked in the case of nodose erythema. The duration of the disease in the cases here tabulated varied from several days to several weeks, the longer duration being due more to fresh outbreaks than to persistence of the original efflorescences. A study of the case sheds but little light upon etiology. Sex was not a factor, and, although 19 cases were seen in the spring, season did not have the predisposing influence usually credited to it, as in the winter months 9 cases were met with, in the summer 12 cases, and in the autumn but 2 cases. Age had apparently some influence, inasmuch as 35 of the 43 cases occurred in patients under the age of 30, as will be seen by the following:

Under 5 years, 8 cases; between 5 and 10 years, 1 case; between 10 and 15 years, 10 cases; between 15 and 20 years, 5 cases; between 20 and 30 years, 12 cases; between 30 and 40 years, 3 cases; between 40 and 50 years, 3 cases; between 50 and 60 years, — cases; over 60 years, 1 case.

The youngest patient was aged 15 months and exhibited the multiform type upon face, trunk and limbs; the oldest was 65, and presented the papular variety upon the backs of the hands and wrists. It is questionable whether treatment had any influence whatever, as at the best it was necessarily empirical; so far as could be judged, saline aperients, antacids and quinia had in some instances a good effect. External treatment, except in the bullous cases, in which mild protective applications were made, was seldom called for.

PURPURA.

Sixteen cases of purpura were seen, 9 males and 7 females. In all the disease was of the milder type, without, as a rule, any constitutional symptoms, and without, too, any adequate explanation for the outbreak. Ten of the cases came under notice during the months of April, May and June.

The youngest patient was aged 4 months, in whom the disease had made its appearance two months previously, and consisted, when seen, of fifteen to twenty patches scattered over face, trunk and limbs; the general condition was good. The oldest patient was a German, aged 57, in whom the disease had lasted for five weeks, and presented the ordinary patches over legs and thighs. In one case a man aged 44, the eruption was chiefly confined to the trunk, the patches, which were numerous, although small, showing, for the most part, the circinate or annular form. (Reported in the *Journal of Cutaneous and Genito-Urinary Diseases* for October, 1887.)

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This circinate tendency is not, judged by the cases here tabulated, so uncommon as has been supposed, as in two others in whom the eruption was upon the legs and thighs, the patches on this latter region displayed this same character. The site of the eruption was in 8 cases upon the legs; in 3 upon the legs and forearms; in 2 it was more or less general in its distribution; in 1 mainly upon the trunk; in 1 on the forearms, and in 1 it was not recorded. The previous duration, as a rule, varied from several weeks to a year or more; in one case the patches had been making their appearance, at irregular intervals, for six years. The remedies employed were chiefly ergot, the oil of erigeron canadensis, and the tincture of the chloride of iron.

LICHEN PLANUS.

Fourteen cases of lichen planus were recorded, ten males and four females. The youngest patient was aged 22, presenting the eruption on the flexor sides of the forearms; and the oldest was aged 72, showing the eruption upon the hands and forearms, mainly on the dorsal aspect. All ages between these extremes were about equally represented. The disease was of the ordinary type; in a few instances the papules were hypertrophic. The eruption was, with the exception of 1 or 2 cases, limited in extent; seated upon the upper extremities, especially the forearms, in 4 cases; upon the lower extremities, more particularly the region of the ankles, in 4 cases; the trunk in 2; arms and legs in 1; trunk and forearms in 1; and in 2 it was not noted. The previous duration varied from several months to a year or longer; in 2 cases there was a history of recurrences. It may be said that constitutional treatment, consisting of arsenic, quinia, strychnia and other tonics, had a positive influence. The external treatment was chiefly by resorcin lotions or ointments, 2 to 10 per cent. strength; tarry lotions, especially the liquor carbonis detergens; thymol lotions and tarry ointments.

BLOODLESS AMPUTATION AT THE HIP-JOINT BY A NEW METHOD.

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Abstract of a Paper read before the Surgical Section of the Suffolk District Medical Society, February 1st, 1893.

Prevention of unnecessary loss of blood during the performance of an operation is one of the modern requirements of successful surgery. Efficient prophylactic hæmostasis has not only greatly reduced the mortality of capital operations by preventing the loss of an amount of blood incompatible with life, but it has proved equally useful in favorably influencing the subsequent reparative processes. Experimental research and clinical observations have demonstrated conclusively that diminution of intravascular tension caused by hæmorrhage is one of the potent factors which favors the origin and spread of infection, and besides retards the healing of the wound.

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The importance of a recourse to prophylactic hæmostatic measures is proportionate to the size of the blood-vessels which must unavoidably be severed in an operation. Thus in amputation of the extremities, without special precautions, the immediate risk to life from hæmorrhage is greater the nearer the operation approaches the trunk. While a finger, or a toe, or even a hand, or foot, might be amputated without the use of a tourniquet, or elastic constrictor, without incurring any immediate risk to life from the loss of blood, such a procedure in amputation at the shoulder- or hip-joint would jeopardize life on the operating table. In all amputations below the shoulder- and hip-joints we have now in Esmarch's elastic constrictor a reliable measure with which we can absolutely control hæmorrhage during the operation, and thus minimize the loss of blood. Elastic constriction is the simplest and safest method of preventing hæmorrhage wherever it can be applied.

The first successful case of hip-joint amputation was performed about the beginning of the present century. In military practice, Larrey obtained the first succesful result after six failures. In 1812 Baffos reported the first successful result in civil practice; but it appears that Mulder, in Groningen, operated with success in 1798. Of 486 cases collected by Luning, the mortality was 70 per cent.—gunshot wounds, 239 cases, mortality 98 per cent.; pathological indications, 153 cases, mortality 42 per cent.

The technique of controlling hemorrhage has undergone many changes, and is still far from perfect. Compression of the abdominal aorta by specially made tourniquets; digital compression of the femoral or external iliac artery; instrumental compression of the common iliac artery against the pelvic brim, devised by Mr. Davy, a long rod being inserted into the rectum and the outer extremity raised, thus compressing the artery where it lay on the pelvic brim, the anus acting as the fulcrum; preliminary ligation of the femoral artery; also of the external iliac; and preliminary ligation of the principal vessels in the incision prior to their division, are the principal among the early devices.

Then came the introduction of Esmarch's bloodless method of operating by elastic constriction, which was soon applied to high amputations of the thigh. "The tube is tightly wound once or twice around the limb just below the flexure crease of the thigh, the ends are crossed above the groin, passing around over the posterior surface of the pelvis, and are finally hooked together by the chain across the abdomen. A firmly-rolled linen bandage may also be laid over the iliac artery, directly above Poupart's ligament, as a pad, and tightly pressed upon the artery by several figure-of-eight turns of a strong rubber bandage."

Mr. Jordan Lloyd employed for the same purpose a common calico roller, which was applied over the external iliac artery, over which was placed a strip of black India-rubber bandage about two yards long, which was doubled, the center of this bandage resting between the tuberosity of the ischium and the anus, the ends, drawn tight enough to arrest the circulation completely, were firmly held at a point corresponding to the center of the iliac crest on the side to be operated upon. In order to prevent slipping away of the band from the compress, these were fastened together with a safety-pin. By this method of compression Mr. Lloyd expected to prevent hæmorrhage not only from the femoral and its branches, but also from the branches of the internal iliac. The prevention of hæmorrhage by this method rests entirely in the hands of the assistant, and consequently cannot be relied

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upon under all circumstances. In disarticulation of the thigh through an external or anterior racket incision, elastic constriction as heretofore practiced has been very unsatisfactory indeed, and main reliance was placed on dividing the tissues quickly after disarticulation, seizing and tying the principal vessels. Elastic constriction has been made more serviceable since Esmarch devised his method of amputation at the hip-joint by first making an ordinary high amputation of the thigh, leaving the removal of the proximal end of the femur until all the principal vessels were tied. Although this method of operating is generally accredited to Esmarch, similar claims are made by the Germans for Pitha, the French for Lacanchie, the Americans for Bontecou. It is well known that Dieffenbach performed it in 1826, and Ravaton proposed it before that time with the advice to make the vertical incision first. Primary re-amputation of the stump requires section of the femur and tends to increase the hæmorrhage from the vertical incision after the ligation of the principal vessels of the stump, circumstances which can hardly fail to add to the gravity of the operation. One great obstacle to the use of the elastic constriction in this operation has been the slipping of the constrictor after the circular amputation. For the purpose of preventing this accident, the thigh below the constrictor has been transfixed by long needles or skewers. Trendelenburg transfixes the thigh by a single needle passed in front of the neck or the femur and beneath the large vessels. Mr. Myles thrusts a stout steel skewer straight through the thigh from before backwards. The needle is made to enter an inch below Poupart's ligament, and just to the outer side of the femoral artery it passes to the inner side of the neck of the femur, and emerges a little above the gluteal fold. A rubber cord in the form of a figure-of eight is passed around the projecting ends of the skewer. Wyeth uses two strong mattress-needles for the purpose of preventing slipping of the elastic constrictor. The point of one is inserted an inch-and-a-half below, and just to the inner side of, the anterior superior iliac spine, and is made to traverse the muscles, passing about halfway between the great trochanter and the iliac spine, external to the neck of the femur, and emerging from just behind the trochanter. The second needle is entered an inch below the level of the groin internal to the saphenous opening, and, passing through the adductors, the point coming out about an inch-and-a-half in front of the tuberosity of the ischium. A piece of strong rubber tube half-an-inch in diameter, and long enough when tightened to go five or six times around the thigh, is now wound very tightly around and above the fixation needles, and tied. The elastic constrictor and needles are removed as soon as the circular amputation is completed and the principal blood-vessels have been tied, whereupon the proximal end of the femur is removed. It appears immaterial to me whether one or two needles are employed, as the object of using them is simply to prevent slipping of the elastic constrictor, which is fully accomplished by using one needle or skewer.

Dr. A. B. Keyes, late interne, Cook County Hospital, has devised a much simpler, and, I believe, better method of controlling hæmorrhage in amputations at the hip-joint by Furneaux Jordan's method. (The *Chicago Medical Recorder*, May, 1892.) After dislocating the head of the femur and separating the periosteum with the attached soft parts down to the proposed point of amputation he constricts the soft parts with a bandage composed of several layers of aseptic gauze folded to about two inches in width, which he ties into a loop and constricts with a hammer handle, "Spanish

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windlass" fashion, after the limb has been rendered comparatively bloodless by holding it for a short time in a vertical position. The circular amputation is then made below the point of constriction in the usual manner. Dr. Keyes reports two cases successfully operated upon by this method. Although the probability of slipping of the constricting bandage is greatly lessened by applying it after the femur has been dislocated and its upper end cleared of soft parts, such an accident is still possible after the circular amputation has been made, and the management of the constrictor requires a reliable assistant, which must be looked upon as a serious drawback in case the necessary assistance cannot be readily secured. I consider the preliminary dislocation of the head of the femur and clearing the upper end of the bone by the external rachet incision far preferable to Esmarch's method of amputation at the hip-joint, provided hæmorrhage can be safely controlled during the subsequent steps of the operation without the aid of a skilled assistant. I prefer this method of dealing with the femur because the removal of the proximal end of the femur after the circular amputation is a much more difficult and time-consuming task than when the whole shaft of the femur can be used as a lever, at the same time the hæmorrhage attending the external incision is much greater after ligation of the femoral vessels than when the incision is made and the head and upper end of the femur are liberated prior to making the amputation and before the circulation in the femoral vessels is interrupted.

Shock, or, as Pirogoff called it, "general traumatic torpor or stupor," cannot be ignored as a frequent cause of death in amputation involving the removal of an entire limb; but Langenbeck does not believe that any of his patients died from it, and accuses chloroform and loss of blood during or soon after the operation as the direct and immediate causes of death. Rose also attributes the fatal issue in his cases to acute anæmia due to hemorrhage. The amount of blood lost is no criterion, as in debilitated persons the loss of a few ounces may turn the balance in the direction of failure.

Statistics show that in the majority of cases hemorrhage was the cause of the great mortality which attends this operation during the first five days, including at least 70 per cent. of the total mortality. Volkmann has called attention to the profuse parenchymatous oozing which frequently attends this operation, and which has done so much towards adding to its great mortality. Enough has been said to show the necessity of taking special precautions in performing this operation to prevent by appropriate measures the loss of blood.

The femoral artery is not the only source of dangerous hemorrhage. It may come from the profunda femoris, which may have a high origin, from the obturator, ischiatic or circumflex, the femoral vein, occasionally quite severe, and Volkmann has reported one case in which two pints of blood were lost by the parenchymatous bleeding, which is often quite severe.

The cardinal points in a typical amputation at the hip-joint are: 1. Disarticulation of the head and isolation of the upper part of the femur from the attached soft tissues through an external straight incision. 2. Elastic constriction of the thigh just below the pelvis until the amputation has been completed and the principal vessels have been tied. 3. Formation of cutaneous flaps and circular sections of deep tissues below the point of constriction.

I will now proceed and give you a somewhat detailed account of the operation I have devised, which will further elucidate the points just enumerated.

External Incision.—The external in-

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cision is Langenback's incision for resection of the hip-joint, differing from this only in so far that it is carried a little farther in a downward direction in order to afford more ready access to the shaft of the femur as far as the proposed line of section through the deep soft parts. The incision is made about eight inches in length parallel to the long axis of the femur directly over the center of the great trochanter, extending about three inches above the upper border of the trochanter. When the knife reaches the trochanter from above downwards its point should be kept in contact with the bone the whole length of the remaining part of the incision. The margins of the wound are now retracted and any spurting vessels, such as the circumflex arteries, secured by applying pressure forceps.

Dislocation of Head of Femur and Clearing of Upper Portion of Shaft.—During this and remaining steps of the operation the body is drawn down so that the pelvis rests upon the lower edge of the table, so that the position of the thigh can be conveniently changed by the assistant who is entrusted with this work. The pelvis is tilted sufficiently upon the opposite healthy side to facilitate this step of the operation. The trochanteric muscular attachments are now severed close to the bone with a stout scalpel. The clearing of the digital fossa and division of the tendon of the obturator externus requires special care. The thigh is now flexed, strongly adducted, and rotated inwards when the capsular ligament is divided transversely at its upper and posterior aspect. The remaining portion of the capsular ligament is severed while the thigh is brought back to a position of slight flexion. After complete division of the capsular ligament, the thigh is rotated outwards, and, if possible, the ligamentum teres is divided; if this cannot be readily done, the head of the bone is forcibly dislocated upon the dorsum of the ilium by flexion, adduction and rotation inwards of the thigh. After dislocation has been effected the trochanter minor and upper part of shaft of femur are cleared by using alternately scalpel and periosteal elevator. In cases where it is deemed advisable the periosteum can be preserved. At the completion of this part of the operation the femur is in a position of extreme adduction. By pushing the femur through the opening as much of the shaft can be cleared as may be desired for the purpose of making a low amputation.

Elastic Constriction.—During the operation, so far, if the surgeon has kept in close contact with the bone, and has used the knife sparingly and the periosteal elevator freely, the hæmorrhage has been very slight, much more so than if this part of the operation had been reserved for the last, as is done in Esmarch's method. Further loss of blood during the subsequent steps of the operation is now prevented by elastic constriction applied in the following manner: The limb is brought down in a straight line with the body, the thigh slightly flexed so as to push the upper free end of the femur forward into and beyond the wound, when a long stout hæmostatic forceps is inserted into the wound behind the femur and on a level with the trochanter minor when in normal position; the instrument is pushed inwards and downwards in a direction about two inches below the ramus of the ischium and just beyond the adductor muscles. As soon as its point can be felt under the skin in this location an incision is made through the skin about two inches in length through which the instrument is made to emerge. After enlarging the tunnel made in the soft tissue by dilating the branches of the forceps, a piece of aseptic rubber tubing three-quarters of an inch in diameter and about three or four feet in length is grasped with the

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forceps in the middle, and is drawn along the tunnel as the forceps is withdrawn. After this has been done the rubber tube is cut in two at the point where it was grasped by the forceps. With one half of the tube the anterior segment of the thigh is constricted sufficiently firm to completely interrupt both the arterial and venous circulation. Prior to constriction the limb is rendered bloodless by elastic compression, or by keeping it in a vertical position for a few minutes, or both of these methods are combined in preventing unnecessary loss of blood The elastic constrictor is either tied, or, still better, after having secured the necessary constriction both tubes are caught and held by a strong pair of forceps at a point where they cross each other. The posterior segment of the thigh is constricted by the remaining rubber tube, which is drawn sufficiently tight behind, when the ends of the tube are made to cross each other and are brought forward and made to include the anterior segment, when they are again firmly drawn and tied, or otherwise fastened, above the first constrictor. As the anterior segment of the thigh contains the principal blood-vessels, this method of applying the posterior constrictor furnishes an additional security against hæmorrhage from the large vessels when divided by the circular incision.

Cutaneous Flaps—Muscular flaps should be avoided in all amputations at the hip-joint. Inclusion of muscles in the flaps is often accountable for incomplete removal of malignant or infective disease for which the amputation is made. An ideal stump can be made by cutaneous flaps and circular section of the muscles. If the conditions for which the amputation is to be made permit it a long oval anterior and short posterior skin flaps should be made. If the condition of the soft tissues of the thigh are such as to render this impracticable, healthy skin must be obtained by making, for instance, a long external and short internal flaps, or a long posterior and short anterior, according to the location and extent of the disease. The long anterior and short posterior flaps are best adapted for a useful stump and efficient drainage. In making the anterior flap the incision is commenced at the lower terminus of the straight incision, dividing the tissues down to the muscles, it is carried downwards then in a gentle curve across the anterior aspect of the thigh, embracing about two-thirds of the circumference of the thigh, it is finally carried upwards to a point on the inner side just below the opening in the skin occupied by the constrictors. The posterior flap is made in a similar manner, but about one-third shorter. The flaps are now reflected to the point where the muscles are to be divided, and should always include the deep fascia. The flaps are to be held out of the way, while the operator completes the amputation by dividing the muscles with an amputating knife. This last incision will correspond to a point on the femur to where the bone has been deprived of soft parts. The incision through the muscles should be slightly conical, with the apex of the cone directed upwards and corresponding to the location of the tube made by the enucleation of the femur.

The sciatic nerve is now resected to the extent of an inch or more, and the femoral artery or arteries tied with catgut in the usual manner. The femoral artery and vein are now isolated and a second catgut ligature, including both of these vessels, applied half-an-inch higher up. In this manner the vein is ligated, while the artery is secured by a double ligature which places the end of the vessel in the best possible condition for definitive closure and cicatrization. The inter-muscular septa are now examined, and any vessels that can be seen are tied. While the posterior constrictor is re-

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moved the posterior half of the stump is firmly compressed by applying a hot moist compress of aseptic gauze over which manual pressure is made for a short time for the purpose of diminishing parenchymatous oozing. After removal of the compress, additional bleeding vessels are secured. The anterior part of the amputation surface is treated in a similar manner; after the removal of the anterior constrictor, but few, if any, additional ligatures will be required here. The double constrictor presents many advantages in the prevention and treatment of hæmorrhage in this amputation. Slipping of the constrictors is an impossibility, and they control the hæmorrhage absolutely while their proper use divides the wound into two halves, each of which is separately treated, thus reducing the loss of blood to a minimum. I applied this method to one case recently, and every one present was favorably impressed with the ease with which the hæmorrhage was controlled during the amputation, and was astonished at the small amount of blood lost after the removal of the constrictors. As this method of amputation does not require the presence of a skilled assistant, it will prove of special value in emergency cases. The operation can be performed with instruments contained in every pocket case. Should an elastic tube not be at hand, the constriction can be made in the manner described by substituting for it a cord made of sterilized gauze or bandage.

The following conclusions represent the principal advantages of the bloodless amputation at the hip-joint as described in this paper:

1. Preliminary dislocation of the head of the femur and clearing the shaft of this bone of all soft tissues down to the proposed line of amputation through an external straight incision requires less time, is attended by less hæmorrhage and shock than when this part of the operation is done after circular amputation, as advised by von Esmarch and others.

2. The external straight incision is the same as von Langenbeck's incision for resection of the hip-joint, differing only in length.

3. After dislocation of the femur the soft tissues are tunneled with a hæmostatic forceps, which is entered through the external wound on a level with the trochanter minor to a point on the inner aspect of the thigh behind the adductor muscless and about two inches below the ramus of the ischium, where a counter opening two inches in length is made.

4. Bloodless condition of the limb should be secured by elastic compression or vertical position prior to tying the elastic constrictors.

5. An elastic tube three-quarters of an inch in diameter and about four feet in length is grasped with the forceps in the center and drawn through the tunnel made by the forceps.

6. After dividing the elastic tube in the center the base of the thigh is constricted by drawing firmly and tying the anterior constrictor in front of the anterior section, while the posterior constrictor, after being drawn tight behind the posterior section, the two ends are crossed and then made to encircle the whole thigh, when the ends are again drawn firm and tied, or otherwise secured above the anterior constrictor.

7. A long and a short oval cutaneous flap should invariably be made in all amputations at the hip-joint.

8. In preference, a long anterior and a short posterior should be selected.

9. The transverse section through the muscles should be somewhat conicle in shape, the apex of the cone corresponding to the tunnel made by enucleation of the upper portion of the shaft of the femur.

10. Resection of the end of the sciatic nerve and ligation of all vessels that can

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be found should be done before the removal of the constrictors.

11. The femoral arteries should be secured by a double catgut ligature half-an-inch apart, the one on the proximal side including also the accompanying vein.

12. The posterior constrictor should be removed first, and all hæmorrhage arrested by ligation and compression before the anterior constrictor is removed.

13. The upper part of the wound corresponding to the acetabulum should be drained with an iodoform gauze tampon, and the remaining part of the wound by one or more tubular drains.

532 Dearborn Avenue.

REPORT OF A CASE OF PSORIASIS OF THE TONGUE, WITH SOME REMARKS.

By J. Allison Hodges, M.D., Wilmington, N. C.

[*Written expressly for this Journal.*]

Henry D., aged 45, presented himself at my office, August 8th of last year, for treatment of an ulcerated surface on his tongue.

His previous history was good, both his father and mother having died of senility. There was no history of specific disease, and, though he had been accustomed to make use of both whiskey and tobacco, he had never done so to an excessive or immoderate degree. He was of a sanguino-bilious terperament, and, at the time of presenting himself to me, appeared to be in rather a debilitated state, being anæmic and excessively nervous. Upon physical examination, his heart and lungs proved to be in a healthy condition, but a slight tenderness was apparent over the hepatic region. There was, however, no enlargement of the liver itself.

Appetite was poor, but digestion seemed unimpaired. The principal annoyance experienced from the lingual ulceration was a dry and pricking sensation over the entire surface of the mouth, and some inconvenience in conversation. The ulcerated surfaces complained of were shallow and about the size and shape of a pea and were confined to the left margin of the tongue. They were then of about two week's standing.

There were two lesions visible at this time. There was no thickening or induration of the organ about the site of the ulceration.

Upon this superficial examination, a diagnosis of herpetic ulceration of the tongue was made, and the patient was ordered to take five grains of calomel, followed by Hunyadi water, this to be repeated in two nights. At the same time tonic doses of the elixir of iron, quinine and strychnine, with three minims of Fowler's solution of arsenic to the dose, was administered. No local application was made.

After several days he presented himself again, the symptoms being no better. The ulcerated surfaces were now touched with lunar caustic and the same internal treatment continued.

After an interval of three days, the diseased spots were healed over superficially, but on the fifth day the ulcers presented the same appearance as formerly, only with an increased tendency to spread. They were then touched with the Pyoktannin pencil, and the same temporary improvement was noticed, but

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was soon followed by a renewal of the ulceration at the same points. The ulcers were now examined more critically, and, on account of the silvery white scales that were seen to cover the surface of the ulceration, together with its red base, the disease was diagnosed as *psoriasis gyrata*.

Then commenced a treatment, both internal and local, which was continued until seemingly the whole *armamentarium medicinæ* was exhausted, and, though the gamut of remedies was run, there appeared during the entire course of the treatment no real and permanent improvement of the local condition. The general physical condition, however, showed some improvement under the tonic and alterative medication.

Internally, the hypophosphites with cod-liver oil, iodide of potassium in large doses, iodide of mercury, sulphide of arsenic, sulphide of calcium, elixir of iodo-bromo-calcium compound, iodide of strontium, vegetable bitters, etc., were prescribed alternately for over three months, while, for local medication, bismuth, potassium chlorate, chrysarobin, aristol, tartrate of iron and potash, diluted carbolic acid, chromic acid, etc., were used in turn, and according to indications. After a short time, local remedies were discontinued, for, while there was almost invariably a temporary amelioration of symptoms from their use, there was noticeable a tendency towards increased irritation of the affected parts. A prescribed dietary was also ordered and persisted in. Despairing of effecting a cure, the patient was recommended to consult an eminent specialist and competent microscopist in the city of Baltimore. A careful digital and microscopic examination revealed no evidences of epithelioma, and the diagnosis of psoriasis was concurred in. This physican, after scraping the exposed surfaces, recommended a continuance of the arsenical preparations in large doses until the systemic effect of the drug was reached. He disapproved of any further local treatment.

As a result of this procedure, the ulcerated surface temporarily cured up with a glazed coating, but again speedily underwent the changes heretofore noted, and is to-day, after nearly nine months, about the same as after the first week of treatment.

This case is reported because of its unique character, and because of a complete failure to induce a permanent cure, believing, as I do, that a physician's failures are oftentimes quite as instructive as his successes.

This, as I have said, is an interesting and unique case, presuming that the diagnosis is correct, and, as yet, I have seen no reason to modify it, for these reasons:

1. The age of the patient; psoriasis rarely occurs the first time after the fortieth year, but usually begins in childhood.

2. The part affected; it usually attacks the scalp and the extensor surfaces.

3. The continuance of the eruption in one particular locality; in this case it never attacked even the dorsum or the right margin of the tongue once, but steadfastly remained where the primary lesion manifested itself, on the left margin of the lingual surface. Once the eruption was noticeable for two days upon the patient's chest.

4. Its small size; it would begin each time, as would be expected, as a small reddish spot, but never attained a size that is often seen in this disease, and, besides, the two lesions never coalesced.

5. Its proneness to become irritated from any local application; even bismuth powders, applied topically, seemed to have this effect.

6. Its chronic character; while this disease is essentially a chronic one, it is only so, usually, in its intermittency.

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7. Its persistent rebellion to all treatment, both local and constitutional.

Now, after a thorough study of the disease, and after a series of careful and extended experiments in the use of medicines, the further treatment of this case seems to resolve itself into one or both of the following procedures: Either to radically scrape the affected tissues and apply liquefied carbolic acid, or to excise the affected spots. Which shall it be?

SURGICAL CLINIC.—NECROSIS OF THE TIBIA; RESECTION.

By John B. Hamilton, LL.D., M.D., Chicago.

Professor of the Principles of Surgery and Clinical Surgery.

[*By our Special Reporter.*]

The patient I present to you was before us last week. He has complete necrosis of the lower end of the tibia and necrosis of the astragalus, both bones projecting through the wound, probably originally a compound or open dislocation. The periosteum being lost, the bone has died in consequence of infection partly and partly from mechanical violence directly applied to the foot.

My advice to this man is that he have his foot amputated. I do not believe an operation for the removal of the lower end of the tibia would be of very much benefit to him. On the contrary, I fear we would have extreme difficulty in obtaining union. The foot, by natural process, will amputate itself if allowed to go on much further.

The conditions in this wound are extremely unfavorable. Remember, I only undertake to perform a resection of the ankle-joint at this man's earest solicitation. We have the parts all about it already infected to begin with. Can this wound be purified so that we may hope for primary union? I fear not. The operation I propose to perform in this case is to cut off the ends of the tibia and fibula with the chisel, then make a linear section of the astragalus, so that I can put the bones together, measurably, and that is the only feasible operation at this time.

I am afraid that the infection has involved the tissue to such an extent that union is scarcely likely to follow. But we will try it. This operation naturally differs from a typical resection. because in this case, while we expect nothing but ankylosis of the joint, we must make a different incision. However, if we succeed in obtaining union, it will doubtles be better than an artificial foot. You will notice the line of incision is slightly angular, the reason, for it will be apparent when we come to chisel away the bones of the tarsus. I find osteomyelitis of the lower end of the bone and pus escaping from the medullary cavity. It is about as hopeless a case as could be possibly undertaken, so far as the probable result is concerned; but the man is so violently opposed to amputation that I promised to give him the alternative. Amputation can be performed later.

We have before us the lower end of the tibia. I shall now remove the outer end of the fibula to correspond in length to the tibia. I shall cut down through the periosteum and the tisues, that are the seat of chronic inflammation, separating them from the bone, then, with

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the chisel, I shall divide the fibula parallel with the division already made in the tibia. I must keep the same angle. I am now chiseling through a shell of bone that has been formed between the fibula and tibia—an exudate from the periosteum—a true exostosis. I have now cut off both the fibula and the tibia, and it now remains to make an incision through the sound portion of the tarsal bone, astragalus, so that I can bring it up and make union with the fresh bony ends.

I am now making two preliminary incisions, one through the tarsus and the other through the tibia. I am paying but little attention to the anatomical conformation of the tarsal bone, simply keeping the line straight. Of course, a typical resection where you have the tendons perfect, where the vessels are not destroyed by long-continued inflammation extending for weeks or months, would be one thing; but as it is in this case we must pick out the bones that are in the way and that have formed redundant callus and *debris* of necrosed bones. I shall now curette all of the granular tissue about this point, remove all spiculæ of bone and pyogenic surfaces, if possible. I shall now bring the tarsal bones to correspond and endeavor to bring the heel up and peg the astragalus to the tibia and fibula with an ivory peg, so that the bones are solidly placed together. That is the object of the operation. I shall now, with a hand drill, make a hole through the fibula in which I can insert the point of an ivory peg, and bring the bones so closely into apposition as possible. I shall finish this by sewing together the periosteum, together with the deep fascia. I now remove the Esmarch tourniquet. There is no vessel requiring ligature.

One would suppose from looking at this extensive wound, the amount of bone that was removed, and the lacerations of the parts that were necessarily made, that hemorrhage would result, but you see there is no hemorrhage which requires to be controlled. Having sutured the skin, we now apply an immovable dressing.

A practical point connected with dressing is that, in an operation such as this is, you should keep the patient fully etherized until the plaster sets, then the bones are better retained in position.

You will have noticed that one side of the os calcis in this operation was eaten away by the progress of the disease, so that it was practically impossible to bring any of the bones to the front of the tibia without sawing through the os calcis and in effect making a Pirogoff amputation. In making a Pirogoff amputation, cutting through the os calcis and bringing the end of it to cover the stump, a decent stump can be made; but you will remember the purpose of this operation was to save the foot, and the patient has been so promised. I desire, however, to make now an unfavorable prognosis. The circulation in the foot is good, and if this were an original wound I would have little doubt of saving it, but as it is, I have serious doubts.

NOTE.—Two weeks later, no attempt at union had been made, and the patient consented to an amputation, which was performed at once.

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Selected Papers.

SCHEDULE FOR PARTIAL REST TREATMENT.

By S. Weir Mitchell, M.D., LL.D., Philadelphia.

(Extract from an Address before the New York Academy of Medicine, December 15, 1892 (*Medical Record*, December 24, 1892).

I urge in your treatment of chronic disorders something of the accuracy we all carry into the management of acute diseases. It is really more essential to write out in detail how a man should live in order to get over a chronic malady than an acute one, where nurse and doctor are ever at hand. Let the following schedule of what we call partial rest explain my meaning:

We have to deal, let us say, with a case of moderate neurasthenia and insomnia, with or without dyspepsia. In a word you are to treat a woman not ill enough to be put to bed, nor well enough to be cured by mere tonics, or even by these with change of air. You, all of you, know these cases. What I propose is to ask this patient to live by schedule, which may be modified to suit the case. I shall not read the too elaborate details, but I shall ask you to accept as exemplars copies of the typical formal scheme, which in every such case I have written out with care, because in many of its details it must vary with the patient.

a. m.—On waking, cup of cocoa. Take bath. (Temperature given.) Lie down on lounge while using drying towels; or, better, be sponged and dried by an attendant. In this process the surface to be rubbed red, or, if drying oneself, to use flesh-brush. Bed or lounge again. Breakfast. Before each meal take three ounces of malt extract; aperient at need in malt. Tonic after each meal. Detail as to breakfast diet. If eyes are good, may then read seated in bed. At 10 to 11 a. m., one hour's massage Rest one hour; may be read to, or read if eyes are good, or knit. At this time, 11 a. m., four ounces of beef soup or eight ounces of milk. At noon may rise, dress slowly, resting once or twice a few minutes while dressing, and remain up until 3 p. m. See children, attend to household business; see one visitor, if desirable. 1 to 1:30 p. m., malt. etc., and lunch. Detail as to diet. At first, as a rule, let this meal represent dinner. Tonic, and after it to rest on a lounge, occupied as above, reading or being read to. If possible, to drive out or to use tramway, so as to get air. Walk as little as possible. On return from drive repeat milk or soup. About 5 p. m., electricity, if used at all. Rest until 7 p. m. Supper at 7 p. m. Detail as to meal. Malt as before, with or without aperient, as occasion demands. Tonic. To spend evening with family as usual. Best not to use eyes at night for near view. Bed at 10 p. m. No letters to be written for two months, when most of these details have to be revised.

After two months of massage it should, in these cases, as in complete rest, be used on alternate days, and by degrees given up. If the nurse or masseuse is able to teach the patient the use of Swedish movements, it is desirable that these or some definite, slowly increased system of chamber gymnastics be continued for months. Finally, walking must be resumed with slow and systematic increase. After the second month I write out a schedule of less restriction, to be followed for six months.

What I dread most at the start, in all cases for rest, is grave insomnia. Whether it be accompanied by a state of mild mental excitement, such as we all know, or is a pure incapacity to go to sleep, or to stay asleep; or whether it be in popular medical belief a congested state, I am apt at once, in bad cases, to use twice a day lithium bromide, at first in 30-grain doses, at noon, at 6 and 9 p. m., given in the malt or not, and soon decreased grain by grain. If I want a positive aid at bedtime, I prefer sulfonal in hot water. But of greater value are

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some of the hydro therapeutic devices—and best of these is what is known, or not known, as the "drip-sheet." Just how this is to be given is of the utmost importance. The following memoranda, which I shall not read to you, but shall ask you to read hereafter, must answer to show how careful one must be, in my opinion, as to these details. I give it here in brief, much as I do to a patient not under the immediate care of a nurse. I cannot help adding that several of the most useful of the water processes are neither taught in our schools, nor so accurately in hydro-therapeutic text-books as to be of much value to the general practitioner.

Memoranda for Use, at Bedtime, of Drip-sheet.—Basin of water at 65° F. Lower the temperature day by day by degrees to 55° F., or to still less. Put in the basin a sheet, letting the corners hang out to be taken hold of. The patient stands in one garment in comfortably hot water. Have ready a large, soft towel and iced water. Dip the towel in this, wring it, and put it turbanwise about the head and back of the neck. Take off night-dress. Standing in front of patient—the basin and sheet behind—the maid seizes the wet sheet by two corners and throws it around the patient, who holds it at the neck. A rough, smart, rapid rub from the outside applies the sheet everywhere. This takes but two minutes, or less. Drop the sheet, let the patient lie down on a lounge upon a blanket, wrap her in it, dry thoroughly and roughly with coarse towels placed at hand. Wrap in a dry blanket. Remove ice wrap; dry hair; put on night-dress. Bed, the feet covered with a flannel wrap.

If all this seems to you as you read it too absurdly minute, I shall feel some regret. Yet believe me, it is worth the trouble, and the drip sheet is a remedy past praise If it fail, a pack may succeed; but this is more familiar to you. I doubt if the use of the drip-sheet is as well known.

Since rest treatment has taken its place in medicine I, and others, have extended its use. In the treatment of chronic alcoholism, rest in bed for a few weeks has obvious value, and, combined with skim-milk diet and massage, is often of use.

In all forms of neuritis, local or general, rest is essential, and in alcoholic neuritis, rest, massage, milk diet, and the use every three to six hours of what I may call cold and heat alternates, will often triumph rapidly. This use of cold and heat is effected by putting the feet and hands in iced or very cold water a few minutes, and then applying in turn to each extremity the greatest heat endurable by mopping with soft towels dipped in nearly boiling water. The limb is then replaced in the cold water, and after three or more alternate uses of heat and cold is taken out, warmed well and left dry.

Obstinate cases of cholera are best treated by rest, absence of friends and of all excitement, massage, and, of course, arsenic, or what not.

Again, I treat all grave cases of morphia habit by absolute rest in bed. This alone has easily-seen advantages. If the case be a very bad one, before I take away the drug I like to use for a time massage, very large doses of bromides, and to train the stomach, which is our worst foe, to endure a diet of peptonized food, preferably milk. The subsequent chance of escape with moderate suffering is thus largely increased, and when we are free from the more immediate consequences of laying aside the opiate, we easily return to normal diet. The common sense of all this must, I think, be clear to you, and some of what I have said is novel as well as useful.

My remarks in regard to neuritis lead me to say a few words about sciatica, which is nearly always some grade of neuritis. At least twenty years ago I began to treat such sciatica by local splint rest with from two to three weeks of local use of ice, if rest alone failed me. Although I have over and over called attention to these means, they have not so captured professional confidence as I could desire. Last year I wrote on them a lecture in the International Series, where it is, I fear, pretty well buried amidst some good and some poor, clinical lectures. As I have of late modified the treatment, and am sure from my own experience and that of Professor Osler, Dr. Sinkler and others, of its great value, I beg to ask you to consider it with me anew. In any obstinate sciatica, where I can exclude spinal cord disease, constitutional states, tumors, etc., I put my case in bed. Then

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I give cod-liver oil, iron at need, full diet, and milk between meals. A long flannel bandage is put on at once rather tightly from the foot to the groin, and renewed twice a day. At the side of the limb a long splint is secured by a few turns of bandage. The splint should reach from axilla to ankle, the knee being bent a little, the heel secured from pressure. The splint and bandage are kept in place from two to four weeks, night and day; once a day, when these are removed, the leg is slowly and very moderately flexed and extended. The treatment is in constant use at the Infirmary for Nervous Disease. If it fails, it is usually because the malady is at first, or has become, spinal. The rationale of its use is, I think, clear: 1. The flannel bandage lessens the blood in the leg. 2. It protects the whole skin surface from the excitation of contacts. 3. The enforced immobility makes all motion impossible, and so the two uses of the nerve cease. It is in splint, and we get physiological rest. Since I have used the bandage the cumbersome use of ice along the nerve track is less often required. At the close of the treatment, massage, used with extreme care, may hurry the recovery.—*College and Clinical Record.*

THE INDICATIONS FOR TRACHEOTOMY AND FOR INTUBATION.

By Herbert L. Burrell, M.D., Boston.

The operation of tracheotomy has stood the test of time, and has saved thousands of lives. Intubation, a comparatively recent operation, has been placed before the profession by Dr. O'Dwyer, and has unquestionably saved many lives. At first it was thought that intubation would supplant tracheotomy. The ease, simplicity and instant relief which is accorded a child with dyspnœa by a successful intubation, as compared with the difficult, bloody and exhausting operation of tracheotomy, led many observers to compare the two operations, and to conclude that intubation would supersede tracheotomy. A number of years have gone by; both operations have been tried, compared, and deductions drawn. It is the writer's belief that each operation is useful, but in a selected field. These fields have not been defined; but by a consideration of the clinical condition of each patient, the anatomical situation and pathological character of the obstruction to respiration, is it not possible to classify them? I shall present clinical types of dyspnœa from obstruction, as illustrating the provisional classification that I have used for the past four years. This classification is simply a step toward determining the specific value of each operation.

FIRST CLASS.

Every practitioner has heard the harsh stridulous breathing of a croupy child. We all know the alarm that fills the household. We all know that most of these cases can be relieved by medical remedies; but if in doubt regarding the relief which can be gained by these medical measures, one need not hesitate to perform an intubation. The performance of an intubation in this class of cases may seem unnecessary, yet it is distinctly a case which, in the days of tracheotomy alone, filled the practitioner with many misgivings.

SECOND CLASS.

A child has been fretful and feverish for a few nights, has complained of a slight sore throat, and within the past few hours has talked hoarsely, but has had no real difficulty in breathing. One finds a child in robust or indifferent health, pulse rapid, temperature elevated to between 100° and 103°, slightly perspiring and resenting interference. It is well known the amount of relief a child receives by improvising a canopy over the child's crib, and giving steam and suitable sedatives. If, however, this child is a long distance from medical aid, and is thereby deprived of the benefit of careful surgical watching, it is well known how at times the stridor increases with great rapidity, until the child is practically moribund before

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skilled assistance can be secured. A skilfully performed intubation will place such a child out of danger, and will relieve both the parents and the practitioner of great anxiety. At the end of a few hours or days the tube can be removed, or is ejected, and the danger is passed.

THIRD CLASS.

A child with the foregoing history, but who, in addition, has distributed over the fauces and uvula, and frequently on the pharynx, a thin, firm, adherent, yellowish membrane. The child has been ill from three to five days, and the hoarseness and difficulty in breathing have been progressive. In this case it is well to try steam; but the length of time which the hoarseness has existed (three to five days), indicates that the membrane has probably extended below the cords, and in this case it is better to perform tracheotomy.

Where, with the above history, the membrane exists as a thin, pellucid film on one tonsil, and the child has been ill but forty-eight hours, intubation is indicated.

FOURTH CLASS.

A young child has been complaining of lassitude, has been slightly feverish, and has lost appetite for several days. It complains of being extremely tired; pulse is rapid, not especially firm; temperature is between 100° and 101°; and the face is flushed. On examining the throat you find distributed irregularly a grayish film with well defined edges. The child has no laryngeal symptoms, and simply requires active medicinal and local treatment. If dyspnœa ensues early in the disease (within forty-eight hours), intubation should be performed. If the difficulty in breathing comes on late in the disease, especially if the edges of the membrane are not well-defined, or where there is great enlargement of the cervical glands, tracheotomy is indicated.

FIFTH CLASS.

A robust child in seemingly perfect health has a sharp attack of vomiting and pehaps a chill. The child is extremely feverish, restless and complains of slight sore throat. A slight redness on the fauces is all that is noticed. On the second day there appears in the fauces, membrane of a leathery consistency, grayish and sloughing, with marked enlargement of the cervical glands. The child has become pale and pinched, the pnlse is small, temperature quite high, and possibly there is diarrhœa. The nares are frequently filled with grayish membrane, and there is a sickening odor about the child. There is quickened respiration, slight stridor, but there is only slight retraction of the epigastrium and intercostal spaces. We all know how powerless we are to meet this condition. It makes but very little difference whether tracheotomy or intubation are performed; they can simply relieve temporarily. Of the two operations, where they are performed for euthanasia, I prefer tracheotomy, for it enables the operator to more thoroughly clear the membrane from the trachea.

SIXTH CLASS.

Œdema of the glottis from steam or fire is *per se* a condition indicating intubation. The scarification of the epiglottis is, of course, attended by marked relief; but where the patient is to be left for any length of time without skilled assistance, intubation is a valuable resource.

The lodgment of foreign bodies in the larynx or trachea indicates tracheotomy. Where pressure upon the recurrent laryngeal nerve exists, it is a question which operation is demanded.

These six classes of cases are distinct in the writer's mind; and the division, while necessarily arbitrary, must be controlled by each individual case. Each patient with dyspnœa should be approached in an inquiring spirit as to the causation. It is absurd to do an intubation upon a child whose trachea and bronchi are lined with membrane. It is also unnecessary to perform a tracheotomy where the membrane simply covers one tonsil, and has slightly encroached upon the epiglottis. In a general way, the younger the patient, intubation is more frequently indicated, from the fact that the larynx is relatively smaller under three years of age; in a general way, when the membrane is below the vocal cords, tracheotomy is indicated.

We can undoubtedly nourish better after tracheotomy than in intubation,

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although by means of blancmange, ice-cream, bananas and cream, bread-pudding, pulp of orange, jellies, soft-boiled eggs, beef-peptonoid, jelly and nutrient enemata, the nutrition of an intubed child can be well kept up. Children differ in their adaptability to feeding after intubation. They will take sherry, champagne, taragona, milk-shake and brandy. After tracheotomy, on the other hand, there is occasionally difficulty in feeding, but, of course, in each instance resort may be had to the use of a feeding tube.

Indications for Tracheotomy: Dyspnœa, caused by pressure from new growths, enlarged glands, cellulitis of the neck, pressure on the recurrent laryngeal nerve (?), foreign bodies in the larynx or trachea; where new growths, fractures of the larynx or trachea (?) or where membrane (either diphtheritic or fibrous) has extended well below the vocal cords.

Indications for Intubation: In the early stages of croupy children; in the cases of diphtheria where the membrane is principally in the fauces; in cases of dyspnœa in children dying of diphtheria, where the parents will not consent to a tracheotomy.

It may be noted that the writer has carefully avoided any reference to statistics in the two operations. The conditions under which the operations are, have been, and will be performed, are so essentially different that such a comparison is, from my point of view, useless. Each operation has its field, and that in the hands of the general practitioner. It, of course, is always better if an operation can be performed by an expert.

The classification which I have given may be modified by further experience, but is submitted for criticism to the profession as a step in the direction of defining the indications for these two most valuable operations.

Every general practitioner should be able to perform both operations. They are each life-saving measures. They both require accurate anatomical knowledge—intubation requiring greater manual training and dexterity than tracheotomy. They should be applied in selected cases.—*Boston Medical and Surgical Journal.*

APPENDICITIS.

By Robert T. Morris, A.M., M.D., New York.

A Clinical Lecture at the New York Post-Graduate Medical School, February 11th, 1893.

Gentlemen:—"How many appendicitis patients have you in there?" I asked, when driving by a grave-yard in company with a physician, one day last week. "Two of my own and four that were seen in consultation," said he. "I was just counting them up when you spoke, and I feel that none of them would be there if they could have had timely operations."

If the grave-stone of every appendicitis patient who need not have died were to give out a light, every cemetery in the land would shine at night.

Before removing the appendices from our two patients this afternoon, I will show two fresh specimens which illustrate widely different types of the disease. This first wicked looking specimen I removed on Tuesday from a patient who was in the eleventh day of an acute general peritonitis. The patient then was moribund. To-day he is recovering. There is always a question as to the policy of operating upon such patients, but acumulative experience enables us to attack cheerfully the most vicious of cases.

Up to the year 1890 we lost a good many appendicitis patients after operation, but from the vast mass of recent data we have deduced a few apparently trifling changes in technique that give our patients chances for life; changing the whole outlook of these operations, just as ideas about peritoneal operations

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in general underwent a transformation a very short time ago.

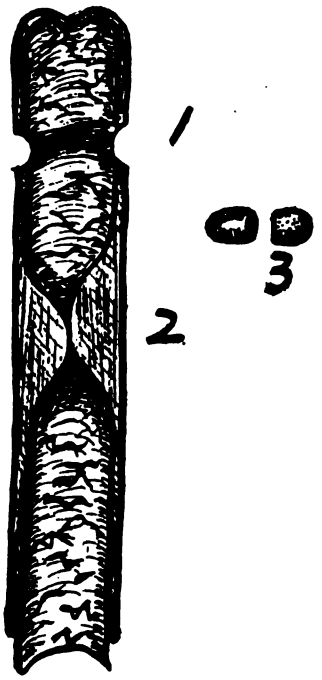

Figure 1.

Longitudinally split appendix. Perforated by concrements. Gangrenous.
1. Point of exit of fecal bullets.
2. Old stricture occluding lumen.
3. Hard dry fecal bullets.

Again let us look at this dark and ragged specimen which has been slit along the free border to show the interior. A stricture at its middle occludes the lumen.

The stricture is a hieroglyphic in high relief, and we can read it. It says that the patient once upon a time had appendicitis, that a bit of mucous membrane was murdered and cast out into the bowel, and that the resulting ulcer filled the gap with a collar of connective tissue.

When the stricture contracted it entrapped two fecal bullets in the distal half of the lumen and left the appendix loaded. Last week the bullets went through the wall and shot the patient.

The physician who asked me to see the case was doubtful about its being one of appendicitis, because there was no particular pain at McBurney's point and because there was no dullness on percussion in the right inguinal region. Nevertheless, he remembered my earnestness in insisting that acute peritonitis in adult males and in children of both sexes was a fire-alarm calling the surgeon to come quickly and put out the appendix. The reason why there was no particularly tender spot and no inguinal dullness was because the abdomen was tense and shiny with acute general peritonitis, and because one of the abscess cavities in the inguinal region was stretched with hissing, stinking gas. How did we find it out? We looked! When I had placed the patient in Trendelenburg's position, and had evacuated a large amount of pus and gas, one of the consultants thought we had done enough. After sterilizing the abscess cavity with peroxide of hydrogen, medicinal, I proceeded to separate all adhesions, and finally came to a large secondary cesspool of pus, containing the riddled gangrenous appendix.

Now the patient can live.

Don't forget what happened after it was thought advisable to rest content with draining the first abscess.

A practical point in the after-treatment of these cases of peritonitis is this: the digestive apparatus is paralyzed so that food ferments instead of digesting, and that means the production of inflating gas and dangerous toxic substances. The patients need predigested food, and in these cases papoid is better than pepsin, because it is in itself clean and carries with it so few of the microbes of fermentation and putrefaction which abound in pepsins.

A word, too, about opium. I am almost done with opium of any form in peritonitis of any sort. Mr. Tait, I believe, says that he has banished it from his pharmacopœia altogether.

My two definitions for opium in peritonitis are these:

1. A drug which stupefies the physician who gives it more than it does the patient who takes it.

2. A drug which greatly relieves the distress of the physician who without it would be compelled to do something rational for the patient who has put confidence in him.

Opium and peritonitis breed a vampire which lulls the patient to sweet repose while his life is being sucked out, and the doctor is looking the other way

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Remove the cause for peritonitis when you can. Remove the products of peritonitis when you can do nothing better. Avoid as carefully as possible the teachings of our honored preceptors who did the best they could in the days when symptoms were treated and not prevented.

An abdomen swollen with peritonitis looks to me like a great big ripe boil and needing the treatment that boils usually receive.

Here is the second appendix. It is apparently normal, as you observe, excepting at the tip, where it is rough and clubbed. I removed it last Thursday from a young man who three weeks ago was laid up for a week with colic and vomiting, associated with swelling and tenderness in the right inguinal region. He found that "something pulled" whenever he made exertion, and the tender spot remained. The roughness at the tip shows where adhesions fixed the tip of the appendix to parietal peritoneum, and that is what caused the pulling and the tenderness. His appendix is what I call a "growler."

The first patient for to-day's clinic is ready. The history is briefly this: Shortly after child-birth, fifteen years ago, agonizing colic, bilious vomiting, rigors, febrile reaction, a lump in the right inguinal region. Acute attacks have recurred several times and of late years the lump has been permanent. Intestinal obstruction has lately become a serious feature of the case. My analysis of her symptoms is this: At child-birth a foreign body in the appendix was compressed until it injured the mucous tube and excited a choking catarrh there. The colic means that the intestine was trying its muscle on disagreeable company, which needed to be forced away. This colic is sometimes awful, and always unnecessary, if the surgeon is near. Bilious vomiting means that absorbed septic matter was being excreted by the liver, and the ptomaine bearing bile on reaching the duodenum mischievously reversed the lever of the duodenum and flooded the stomach with bile. A reversed peristalsis caused by certain irritants is familiar to some of you as a laboratory experiment. The rigors and the febrile reaction meant that microbe products were poisoning sympathetic nerve centres. The inguinal lump indicated that local peritonitis had welded several structures together in order to protect the peritoneal cavity against the company that the intestine was trying to rid itself of. The intestinal obstruction means that adhesions have contracted.

The peritoneal exudates made a lymph cake. Sometimes this lymph cake is a simple pound-cake, that the peritoneum digests as soon as the appendix has been temporarily appeased. Sometimes it is a cream cake, and the pus, if not absorbed, finds its way into a large vein or into the ureter or into the bladder, or somewhere where no reputable surgeon would think of making an opening. Nature tries to do some surgical work, but she is a good deal more of a success at making lilies.

Then, again, we are never sure whether nature prefers to save the patient or to encourage a particularly fine bed of microbes. It is a pretty conceit for us to assume that she cares more for one specimen of *homo sapiens* than for a whole lot of *streptococcus pyogenes aureus*. The presence of a lymph cake in the vicinity of an appendix vermiformis is the piteous signal of the peritoneum for help, and the sympathetic surgeon must respond instantly, bearing in his hand the little wand that will vanquish the witch. A diseased appendix which is not walled in with lymph cake needs equally prompt attention by the surgeon.

Under procrastinating medical treatment by the good physician, a surly appendix may often be coaxed back into its hole where it mutters and sulks and prepares for another spring at the patient.

Our patient is now placed in Trendelenburg's posture. The reason for that is because we do not want to play a jack-in-the-box game with intestines, but prefer to attend strictly to business. Another reason is because we wish to have pus run out instead of running in. Another reason is because one look at the involved parts is better than two feels and four guesses. The site of the appendix is exposed through the customary lateral incision. The lump is found to consist of a heterogeneous mass of omentum, mesentery and ileocæcal intestine, all firmly welded together. When the bass are biting fast and my line gets into this kind of a

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snarl, I cut out the whole snarl at once and throw it away. I believe that we must do that in some of these old appendicitis cases with intestinal obstruction, but I have succeeded in undoing so many similar snarls that we will try it once more. Guided by the small granular lumps of fat, we separate the adhesive omentum. That is very easy. Guided by the direction of the blood-vessels, we separate the adhesions of the mesentery. That requires sharp eyes, for the bowel, as usual, rolled itself up in mesentery when it first became frightened. Guided by the direction of muscular tissue, we slowly work the ileum free. Here comes a sudden burst of pus, which runs out upon the abdomen because of the Trendelenburg position. The abscess cavity is irrigated with peroxide of hydrogen. That is done because the peroxide is a searching sterilizer, and it throws pus and debris out of nooks and crannies. It is easy to observe that the appendix has practically gone into solution in the abscess cavity, and here I find a piece of apple-core encrusted with phosphates that has caused all of the trouble. The cæcum has disappeared. It was drawn up by adhesions, strangled, and forced to join the abscess. There is no ileo-cæcal valve, but in its place a rigid, narrow, tortuous channel, about five inches in length.

Gaze upon this wreck of vitals, progressively by successive attacks of appendicitis, and then consider the responsibility of the physician who in appendicitis cases advises the patients to wait. How easy and safe an early operation in this case! How desperate the operation now! I ought to resect the intestine right here, but the patient has been absorbing pus for several months, so I will make a fecal fistula to relieve the ileum, and resect the intestine a month later. The shock we will treat with nitrate of amyl to the nose at first, and then hypodermatic injections of nitro-glycerine and strychnine, together with the routine resources of hot bottles, hot rectal injections and elevation of the feet.

Our next patient is the genial Dr. Robert Kennedy, of proteinol fame, whom most of you know. Judging from his appearance, he has never lived upon anything more artificial than a thick, tender porter-house steak. His appendix must come out, however, and we shall give him his own proteinol for the next week, because a food of that type will furnish the best of nourishment during the early days of convalescence. Two years ago, after exposure to cold sea winds, the Doctor was suddenly attacked with colic and abdominal cramps, but at the end of a week was practically well again. Eight months ago he was again attacked in the same way, but with added symptoms of rigors and vomiting, together with pain and tenderness in the right inguinal region. After subsidence of the acute symptoms there remained a persistent feeling that something was wrong with the appendix. He was constantly inclined to press with his hand over the region of the appendix, and found discomfort in certain positions when sitting. That is a pretty good history of early catarrhal appendicitis.

After his history had been taken, our conversation was something like this:

Q. Well! What do you advise me to do about it?

A. That depends. If you are always where good medical attendance is within easy reach, it would be as well to pay no particular attention to the appendix at present.

Q. But I travel a great deal, and am liable to be caught with an acute exacerbation at any time and place, am I not?

A. Certainly!

Q. Is the next attack likely to be more severe or more mild than the last one?

A. No one can possibly predict.

Q. Is sloughing or perforation as likely to occur in the third attack as in the tenth one?

A. Surely!

Q. Can I recover completely and have no further trouble without an operation?

A. Yes.

Q. Am I likely to?

A. No.

Q. What are the dangers of an operation now?

A. I have never been anxious for my patient, no matter what the complications were, excepting in desperate cases with pus and septicæmia to deal with at the time of operation; when these two features were absent the technique which buries the stump of the appendix and which ensures against ventral hernia later, has given me perfect ease and

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comfort in a responsible position, and the patients have made uninteresting recoveries.

Q. The greatest danger from the surgeon, then, is when there is greatest danger from the disease?

A. *A la bonne heure!*

Q. Well, I like the opposite combination better! If by having my appendix out now, I can escape the ever-present dread of recurrent attacks, and can save the time lost in attending to mild attacks; if you do not now dread the operation, and if you will dread it when I am in danger from the disease, why is it not good business judgment to decide that the appendix should come out?

A. That is for you to say. I am at your service.

Q. When will you take it out?

A. On Saturday, 4:30, p. m., if you are willing to go before my class at the Post-Graduate Medical School. The matriculates have shown unusual interest in my appendicitis cases there.

Final. All right! Glad to give them points! I'll be there!

And here he is. A man in fine health, suffering only a little discomfort, deciding to have his catarrhal appendix removed as a plain matter of forethought and discretion.

The patient being placed in Trendelenburg's position, my incision is made over the normal site of the appendix. This incision is about two and a half inches long, through skin and muscle, and about one and one-quarter inches long through transversalis fascia and peritoneum. Intestine presents; I see by the longitudinal bands that it is colon. Passing through the fingers in a direction which will put the cæcal peritoneum upon the stretch, we soon come to a halt. The appendix must be very near. Here is its base presenting in the wound. I pull the appendix out through the opening. It is about five inches long, hard and congested. While an assistant holds it with forceps, the mesentery of the appendix is ligated with catgut and divided, the peritoneal and muscular coats of the appendix are clipped through at the cæcal junction. The mucous tube is ligated well down into the cæcal mucous membrane with the finest of eye-silk. The peritoneum of the cæcum about the base of the appendix is scarified with the point of a needle until pink serum exudes, and those of us who are accustomed to experimental abdominal work in the lower animals, realize that this is one of the most important points in the technique, and must never be neglected in cases like this one. The mucous tube is snapped away, leaving a trifling stump. Four Lembert sutures of catgut bury the stump. If the silk ligature and its tiny stump must escape for any reason, they would go into the lumen of the bowel. The relative position of structures after this method of suturing is shown in Figure 2.

Figure 2.

The method of ligating, which is apt to leave an Esquimaux window at the site of the appendix, is illustrated in Figure 3, and I should have no confidence in such a scar.

Figure 3.

In closing the wound of the abdominal wall, peritoneum and transversalis fascia are sutured with one tier of catgut. Muscles receive a second tier of catgut sutures. Superficial fascia is separately united with another tier, and skin and fat are honored with a fourth tier. This patient now will not have a ventral hernia.

Let us examine the specimen removed. As I slit it along the free border you will observe that the mucous membrane hastily bulges out. It is what I call a "pop-corn" appendix, and on comparing it with the normal portion of this other appendix the reason for the name is apparent.

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Figure 4.

Transverse section of longitudinally split appendix. Nearly normal.

1. Mucous membrane bulging a little.
2. Submucous tissue not thicker than the combined muscular and peritoneal coats.
3. Muscular and peritoneal coats.

The condition shown in Figure 5 is, I think, characteristic of catarrh of the appendix. The elastic mucous tube apparently swells within the outer tight

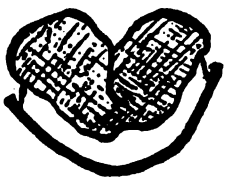

Figure 5.

Transverse section of longitudinally split appendix Catarrhal. A "pop-corn" appendix.

1. Mucous membrane bulging prominently.
2. Subcutaneous tissue about seven times thicker than the combined muscular and peritoneal coats.
3. Combined muscular and peritoneal coats.

tube until the crowding cuts off circulation, and then little or big sloughs of mucous membrane occur. These either decompose and escape into the bowel, leaving an ulcer, or they escape bodily through the wall of the appendix, leaving a perforation. That, I think, is a pretty good history of appendicitis, no matter whether the choking catarrh was excited by exposure, or by foreign bodies, or by local tuberculosis, or by amœbæ coli, or by nematodes, or by typhoid fever, or by dysentery. So far as I can learn, authors have not noted the fact that patients sometimes depreciate rapidly in health without discoverable cause for a week or for several weeks before the first acute symptoms of appendicitis appear. The natural explanation is that they are absorbing products of the catarrhal inflammation at the appendix before the catarrh has swollen the mucous tube enough to make strangulation. It is sometimes asked how can I reconcile this theory and the condition of dropsy of the appendix, in which all structures are widely distended. My answer is: Slow, low grade inflammation, giving time for dilatation of all structures, and not associated with tonic muscular spasm of the muscular wall of the appendix, such as we would expect in acute catarrhal inflammation. The theory of causation of appendicitis, carried out to meet the common principal symptoms, is arranged thus:

Colic.—Simple vomiting. Right inguinal tenderness, choking of swollen mucous tube in tight muscular tube, which is made more rigid by tonic muscular spasm.

Colic.—Bilious vomiting. Right inguinal tenderness. Formation of tiny or large mucous tube sloughs, and absorption of septic products from the decomposing sloughs.

Colic.—Bilious vomiting. Right inguinal lump. Oozing through or slow perforation of appendix wall by sloughs and other contents, met by lymph exudate from peritoneum.

Colic.—Bilious vomiting. Collapse. Rapid perforation of appendix wall by sloughs and other contents, allowing no time for formation of protecting lymph exudate.

The reason why the mucous tube is so hard pressed in the tight tube of peritoneum and muscle is because of the great round cell infiltration and serous distension. I will ask Dr. J. C. Smith to make a section of this catarrhal appendix in the pathological laboratory, and then give us a photo micrograph.

It seems strange to me that the life insurance companies pay so little attention to a disease which daily claims its large quota of deaths. Patients who have recurrent appendicitis can at present take out heavy policies in anticipation of a fatal termination of the malady. The insurance companies will not always discover that a patient has appendicitis if the diagnosis which patients bring to the surgeon form any guide. I am keeping a record of diagnoses that were made for patients of mine who had typical appendicitis and the list up to the present time includes bilious colic, bilious peritonitis, gall-stones, typhoid fever, perityphlitis, cæcitis, la grippe, abscess of the abdominal wall, pyosalpinx, ovarian abscess and psoas abscess.

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I wish the physicians who make the diagnosis of typhlitis, perityphlitis and iodopathic peritonitis could know how farcical such a diagnosis sounds to those of us who have frequent occasion to look and who find the cases to be appendicitis.

This subject of appendicitis, gentlemen, is very near to my heart. Friends of mine attacked in the prime of manhood are now gone forever, because their physicians waited to see if they would not get better without operation. When they were a little worse consultants were called in, and the consultants gave cheer and hope to the anxious families by describing similar cases of theirs which had made most excellent recovery. Finally, when my friends were dead, the physicians said: "There! those were the cases for early operation!"—*New England Medical Monthly.*

Society Reports.

PURULENT OPHTHALMIA.*

By Charles W. Kollock, M.D., Charleston, S. C.

This subject is old—is hackneyed and common, and probably devoid of interest to many, even in this small body, but it is my intention to force it upon you without an apology, to prove by figures that blindness is increasing faster than the population, and that this is due to carelessness on the part of physicians: (1) by neglecting individual cases, and (2) by neglecting the advocacy of preventive measures for stamping out a disease that renders blind more than one-tenth of the entire number of blind persons in the world.

In 1870 the population of the United States was, 38,558,371. The number of blind was, 20,320. In 1880 the population was, 50,155,783. The number of blind was, 48,928. The population had increased 30.09 per cent. in ten years, whereas blindness increased 140.78 per cent.

In a valuable paper read before the American Ophthalmological Society in 1887, by Dr. Lucien Howe, of Buffalo, N. Y., on the "Increase of Blindness in the United States," are the following suggestive points. Taking the average cost of supporting a blind person in different asylums, he estimated that for one it would be $2.00 a week, or $104 a year; clothing, $28.00—total, $132. But these persons are not producers, they do not earn what they would in health, and this must be added to the whole cost. Putting the lowest wages for a man at $1.20 per day for each working day (and not one could make that), and the wages of a woman at 40 cents a day, the total yearly cost to a community for each man is $504, and for each woman $256. This, Dr. Howe calculates, amounted in 1880 to not less $16,383,272, and if anything like the same increase had continued, would in 1887 have been considerably over $25,000,000. While these figures are not strictly accurate, they most assuredly do not exaggerate the condition of affairs.

Having proved that blindness exists to an alarming extent, that it is on the increase, that between 1870 and 1880 it increased at a rate more than five times as great as that of the increase of the population, does it not behoove us to be up and stirring, to make laws relative to

*Read before the South Carolina Medical Association, April 19th, 1893.

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the care and management of contagious eye diseases? As yet South Carolina has not been over-run by those vast hordes of foreigners who are daily flocking to our shores, but her time must come, her many and varied attractions must soon draw their attention. With these people come disease and lawlessness, and unless we are in a position to deal with them promptly and firmly from the outset, there will be many an unhappy day in store for us. Several States, and among them Maine and New York, have enacted laws relating to contagious eye diseases. That of Maine reads as follows:

"Section 1. Should one or both eyes "of an infant become reddened or in- "flamed at any time within four weeks "after its birth, it shall be the duty of "the midwife, nurse or person having "charge of said infant to report the "condition of the eyes at once to some "legally qualified practitioner of medi- "cine of the city, town or district in "which the parents of the child reside."

"Section 2. Any failure to comply "with the provision of this act shall be "punishable by a fine not to exceed one "hundred dollars, or imprisonment not "to exceed six months, or both."

Purulent ophthalmia and granular conjunctivitis are the two most dangerous and contagious of eye diseases. The consideration of the former will be taken up in this paper.

All forms of ocular discharge were considered contagious by Von Graefe, and this is preëminently true of purulent or gonorrhœal ophthalmia. Among children, where its greatest ravages are made, it undoubtedly is transmitted during the passage through the parturient straits, and therefore our first efforts should be toward rendering these parts aseptic.

Most women have a catarrhal discharge from the vagina during the latter months of pregnancy, and when a woman is known to have gonorrhœa no efforts should be spared in endeavoring to bring about a cure before delivery, but if this is impossible, then at frequent intervals during the first and second stages of labor the vaginal walls should be thoroughly cleansed with any aseptic solution. Even with these precautions we cannot expect to rout the gonococcus from the succulent rugæ of the vagina, which must be pushed out as the head descends and presses upon each portion in turn. In 1880 Credé began his famous preventive treatment of ophthalmia in newborn infants. After numerous experiments in cleansing the eyes immediately after birth with different preparations, all of which lessened the percentage of attacks, he finally decided upon the instillation of one or two drops of a two per cent. solution of nitrate of silver as being the most reliable of all. By this treatment in 1880 (seven months), 211 children, 1 case; in 1881, 400 children, 1 case; in 1882, 418 children, 2 cases; in 1883, 131 children, no case. The patient in 1880 was not disinfected.

Abegg used pure water immediately after birth, and among 2,266 births 66 had ophthalmia.

Hecker used a 1 per cent. solution of nitrate of silver, but found it was not strong enough, and the number of cases was not reduced.

Of 351 children who were born at Maternity Hospital, Blackwell's Island, in whose eyes the 2 per cent. solution of silver was used, not one had ophthalmia.

Kònigstein saw in Späth's clinic 1,092 children for whom no prophylactic measures were adopted, and there was blenorrhœa in 4.76 per cent. and catarrh in 14.5 per cent. Later in the same clinic 1,300 children were treated by Credé's method, and ½ per cent. had blenorrhœa and 6 per cent. catarrh.

Bayer, in 1881, treated 361 children at the Stuttgart Lying-in Hospital by Credé's method without a single attack, while in 1880, of 354 not treated, there were 34 cases.

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At the Royal Lying-in Institute in Dresden, from October 1st, 1883, to July 10th, 1884, 1,002 children were born and all were treated by Credé's method, and not a single case of ophthalmia occurred.

The value of Credé's method can scarcely be questioned after having heard the above statistics, and if the physician is present when the child is born, it can be easily and thoroughly carried out, but among the poorer classes, and especially the negroes of our own State, the presence of a physician at the bed-side during labor is the exception. However, something must be done to educate the lower classes in this most vital matter, and in no way can this be better accomplished than by enacting laws similar to those of New York, Maine and other States, which make the mid-wife responsible for the reporting of these cases, and not until such action is taken can we look for any decrease in blindness from this cause.

Ophthalmia in the new-born begins at any time from a few hours after birth until the fourth or fifth day, and sometimes even later, but the later cases have usually been inoculated after birth. The cases which begin early are the most severe. The eyes first become reddened, soon a muco-purulent discharge commences, the lids swell rapidly and close the eyes, and the now purulent discharge wells forth whenever the lids are separated. The discharge re-forms rapidly, the eye is constantly bathed in pus, and unless carefully guarded the cornea soon softens and sloughs. Treatment must be active, constant and thorough. Extreme cleanliness must be insisted upon; the eyes should be cleansed as often as is necessary for keeping the pus from collecting, and usually this will be from two to three times in every hour. Pledgets of absorbent cotton, soaked in a saturated solution of boric acid, should be gently employed for removing the pus from the lids and orifice, and then the same solution may be carefully thrown from a bulb syringe under the lids until all discharge has been washed away. Chlorine water has been highly recommended in these cases, and its antiseptic powers are certainly greater than any of the solutions of salicylic acid, carbolic acid, permanganate of potash and perchloride of mercury, that have been employed for these and similar cases. The instillation of a 2 per cent. solution of nitrate of silver twice a day is a necessary adjuvant. The solution acts better and finds its way more thoroughly (Andrews) into every portion of the *cul-de-sac*, when dropped in, rather than when applied with the brush or pledget of cotton.

Vaseline has been highly recommended by F. M. Wilson as a protective agent. He uses the white vaseline, and squeezes it from the artist's tubes under the lids. Between cleansings, the lids should be kept covered with pieces of cotton saturated with ice-water. It is rarely necessary to vary this treatment, except in unusually severe cases the solution of silver may be increased in strength to 5 or 10 per cent. These solutions should be applied to the lids alone and immediately neutralized by a solution of salt.

Haziness, or any sign of corneal affection, indicates the necessity for employment of atropine, which allays pain and helps to cure by quieting irritation and preventing iritis. When ulceration extends, in spite of the above treatment, it has been advised to resort to the actual cautery, and several cases are reported to have been saved by this treatment. Division of the outer canthi has been tried with benefit where the pressure on the cornea was great, and by some the upper lid has been divided vertically and the flaps laid back until the disease began to subside. The discharge may be effectually removed by syringing with a solution of peroxide of

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hydrogen, but whether cases so treated make quicker recoveries, is not known to the writer.

Finally, these cases should not only be seen once a day (and oftener, if necessary) by the physician, but should actually be cleansed and every portion of the eye critically examined by him in order that the slightest tendency toward corneal complication shall receive early recognition and special care. Night and day the same watchfulness should continue until, by a subsidence of all symptoms, it is known that danger has passed. When possible, a nurse should be engaged to attend only to the eyes, and all persons about the sick-room should be warned of the danger of contagion. Pledgets of cotton used in cooling and cleansing the eyes, must be burned immediately after having been used. If a mother has gonorrhœa and the child has escaped, great care must be exercised in allowing the child to nurse. The nipples and mammæ should be thoroughly aseptisized, a clean cloth placed between the child's head and the clothing of the mother, and on no account should the child be allowed in bed with the mother except for feeding.

RICHMOND ACADEMY OF MEDICINE AND SURGERY—REGULAR MEETING, APRIL 11, 1893.

[*By our Special Reporter.*]

Dr. Hugh M. Taylor, President, in the chair.

Subject: ABDOMINAL DRAINAGE.

Dr. Stuart McGuire opened the discussion on Abdominal Drainage. He reported the case of K. W., of New Orleans, aged 52, mother of 11 children. She came to him in February last, when he found her almost helpless, with a large abdominal tumor. Operated on her some time in March, removing a tumor weighing 77 pounds. An incision five inches long was made in median line, exposing the tumor, which was extensively adherent to the parietal peritoneum; separating these attachments with a steel sound, ten or twelve cysts were emptied with a trocar, the sac partially drawn out of abdomen, two or three omental adhesions ligated and pedicle transfixed with a double thread, tied, cut and dropped into the cavity; peritoneum was flushed out with sterilized water, everything perfectly toileted, but no drainage-tube was used as every law of antisepsis had been observed. Time of operation, forty minutes.

Patient did well for a few hours, when she began to complain of pain. Temperature 101 2-5°. Salines were given, but rejected; enemata of salts, glycerine and water were given; also small doses of calomel, with no effect, however, and patient grew worse; thirty hours later, temperature 104 2-5°, pulse 140, belly distended and patient almost in collapse. The wound was then opened, when about a quart of bloody serum was discharged, belly flushed and patient began to improve at once; temperature fell 2° in the next hour; four weeks later she left the hospital a well woman.

Recognizing his mistake in not using a drainage-tube, he thought it best to make a closer study of when and how to use a tube. He thought the subject of drainage far from fixed as to any certain law—some surgeons claiming drainage in all cases, others stigmatizing it as a confession of imperfect operative work

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or faulty technique, while a third, more conservative class, held that it should be used only in carefully selected cases.

The object of drainage is to remove fluid or debris from the abdominal cavity, relieving it from septic germ invasion. This can be accomplished in several ways—indirectly by saline purges, or directly by tube-wick or strips of gauze.

He seemed to think Tait's saline drainage possessed none of the dangers and disadvantages of the glass tube, if used as soon as there are any signs of septic trouble, and given in large doses, frequently repeated; but preferred the glass tube first suggested by ———, of Strausburg, for simplicity and utility, not only carrying off all the fluid, but as a warning to any hemorrhage that might occur. It has its disadvantages, though, as it retards union and predisposes to hernia, favoring septic infection by admitting air; also it may cause sloughing of portions of gut, or loosen the ligatures, become fastened by adhesions, or have omentum insinuated into its perforations and become difficult to remove, and as it became plugged up in forty-eight hours, its use was ended. It should be used when peritonitis with effusion exists, when colloid or semi-solid matter has escaped, when the peritoneum has become sodden, infiltrated or thickened from inflammatory changes and incapable of rapid absorption, when coats of intestines and bladder are wounded and fistula is found, when cavity is contaminated by fecal matter, pus or other septic material.

He thought Price's modification of Kohnlic's the best tube in use—straight cylinder, four to six inches long, one-third to one-half inch in diameter, open at both ends, lower end with perforations, upper surrounded by a rim or collar. To pass it, use two fingers as guides, passing perforated end down to bottom of the *cul-de-sac*, collar resting at inferior angle of wound, seeing that no loop of intestine is beneath the tube, and that the tube is not too long or too short to carry off all of the fluid. A rubber dam is placed over the rim of the tube and absorbent cotton over the mouth, then the four corners of the dam are brought together and pinned and dressing applied. The tube itself is not essentially a drain, as it cannot empty itself. To do this, use a small piece of gauze, or syringe, to whose nozzle attach a small piece of rubber tubing; tube should occasionally be elevated and twisted to prevent insinuation of omentum into the perforations, this to be aspirated every fifteen minutes; first have them every hour or hour and a half, until removed. The tube is not to be left more than forty-eight hours, then governed by amount and clearness of fluid.

He spoke of gauze and Morris' gauze and silk-wick—thought they did better service in deep abscesses, hemorrhage and oozing not controlled by ligatures. But in all these cases it acts as a compress rather than a drain, and becoming saturated, it becomes itself a source of infection, carrying off water and serum, but not the pus and blood.

He concluded by saying that in simple cases purgation is indicated. When complications indicate direct drainage, use the glass tube; when combined hæmatosis and drainage is required, or adhesions desired, use the gauze. In some cases, however, a combination of the different methods is advisable.

DISCUSSION.

Dr. Geo. Benjamin Johnston thought Dr. McGuire had covered the ground so thoroughly in his paper, that there was little left to say except to reiterate. It was to him a most difficult matter to say who to follow as to the best manner of abdominal drainage; for some surgeon's advocate drainage of every kind, while others confine themselves strictly to one

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rule. It is no doubt often unnecessarily used, but in most cases the doctor thought the surgeon should decide for himself the manner most applicable to the case before him. In cases perfectly aseptic, where there is no fear of contamination, drainage may be omitted. It is his rule in general practice to drain in all doubtful cases, and when properly used it is a means of saving many lives. He preferred the glass tube—one that best fits the case—letting it run to the bottom of Douglas' pouch, and he did not trust to gauze to carry off the debris; used a syringe to withdraw the pus and fluid. He enjoined a special caution upon the use of the syringe, but if kept in antiseptic glass jar, there was little danger of introducing septic material when used. Occasionally, half turn the tube to prevent adhesion. The length of time for the tube to remain depends upon the nature of the case, but always keep it in situ as long as fluid escapes, and he did not think at this age the probable resultant hernia any excuse for removing the tube too early. He did not use gauze or wick except in special cases.

The following cases were reported:

Dr. Charles M. Shields exhibited the specimen of a glioma of the retina removed the day before, which he thought would be of interest, as it now comes under the head of possible operative measures, whilst heretofore it has been looked upon as almost hopeless. The specimen was removed from a child six years old. One year before the mother had noticed white spots in the pupil and eye enlaged; six months later, the eye protruded very much and the attending physician diagnosed inflammation of cellular tissue and gave favorable prognosis. But the eye grew worse and continued to enlarge until the patient was brought to the doctor a few days before the operation, when the swelling was so great as to produce strangulation and ulceration of cornea. In operating the tissue was dissected back and as much of nerve taken out as possible, close down to the foramen, and cavity washed out with chlorinated zinc, 1 part, liquor althro. 2 parts, and packed with gauze. The doctor thought this not a very infrequent trouble in children, had seen it in both eyes in a child one year old, and if operated upon early, they generally do well, but if put off, they frequently recur in other parts of the body, i. e., in the liver. The specimen exhibited was very hard, enveloping the entire eye—a true glioma.

Dr. Geo. Benj. Johnston exhibited specimens of ovaries and tubes removed the day before.

Case 1.—Lady, æt. 38; married fourteen years; sterile; catamenia regular, but accompanied with a good deal of pain in ovaries; violent dyspepsia. The year before he had treated her for endometritis, and relieved her. Later on her symptoms became more grave, ovaries very tender and painful. He operated April 10, 1893, found both ovaries under grave cystic degeneration, and left tube so much inflamed, that in spots it looked as if it would rupture.

Case 2.—Woman, æt. 18; health perfect; contracted gonorrhœa from her husband just before her second confinement. Three months after the birth of her second child she complained of severe pains about tubes and ovaries, which continued so constant that the doctor operated a few weeks later. He found pyo-salpinx, ovaries very much inflamed and diseased, and in left side a very large cyst, tubes much bent upon themselves, tortuous and adherent, while the fimbriated extremity of the right tube was almost obliterated. He thought it a very rapid infection from gonorrhœal contamination, and advised a proper precaution in these cases.

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Communications.

RALEIGH, N. C., Feb. 18, 1893.

Editors North Carolina Medical Journal:

I send you herewith a list of the resi dent physicians of North Carolina in 1822. It is taken from a little book now extremely rare, if not unique, in the possession of the North Carolina Historical Society at Chapel Hill. I thought it would prove interesting to many of the profession, and so I turn it over to you to publish, if you see fit. I enclose the title page of the "Register."

Yours truly,

K. P. BATTLE, Jr.

RESIDENT PHYSICIANS,

AS ENUMERATED IN

THE NORTH CAROLINA REGISTER AND UNITED STATES CALENDAR, for the Year of Our Lord 1823; Being the Forty-seventh of the Independence of the United States; Compiled from Authentic Documents, by the Rev. Colin McIver. The Astronomical Calculations by John Beasley. Raleigh: Printed by J. Gales & Son, 1822.

Anson County—John King, T. D. Parke, Wm. Mendenhall (?), C. Watkins.

Ashe—None.

Beaufort—Hugh McCullaugh, David Telfair, John Elliotte, David Freeman, Wm. Magimpsey.

Bertie—John E. Wood, Joseph B. Outlaw, James Watton, James Jones, Edmund P. Godwin, Wm. R. Minor, —— Himstead, Wm. Henderson.

Bladen—Alexander McDowell, —— McLeod, R. L. Seawell.

Brunswick—Starling Everett, J. C. Cletheral.

Buncombe—Robert B. Vance.

Burke—Thos. Bowchell, Samuel Tate.

Cabarrus—Charles Harris, Stanhope Harris, Wm. Houston, Tilman Davis.

Camden—Caleb B. Nash, Samuel Robinson, Phineas Sanburn, J. H. Ramsay.

Carteret—James Manney, James W. Hunt.

Caswell—John McAdam, John T. Garland, P. H. Thomas, Henry McAdam, John Comer, Isaac N. Jones, John L. Graves, Robert Thurman, Edward M. Foulkes, Willis Taylor, Jonathan Harrison, John Jones, Nathan Turner.

Chatham—Francis Farrell, William H. Strong, John Degraffinreidt, Thos. H. E. Degraffinreidt, Frederick Hill, J. H. Hawkins.

Chowan—James Norcom, M. E. Sawyer, J. C. Skinner, Edmund Harvey.

Columbus—A. Pierson.

Craven—Peter Custis, John T. Boyd, Wm. Boyd, Frederick Blount (?), Elias Hawes.

Cumberland—Benj. Robinson, Hiram Robinson, Edward McKay, Jas. Moffett, William Moffett, Edwin Degraffinreidt, Goodorum Davis, Kenneth Clark, Thos. N. Cameron.

Duplin—Thomas Hill, Stephen Graham, Wm. Frederick.

Edgecomb—Thomas H. Hall, John F. Ward, Benjamin B. Hunter, David Dancy, Benjamin Boykin, Henry Brownrigg, Richard Bell, Wm. H. Shollington, Jas. Philips.

Franklin—Willie Perry, Wm. Verell, Solomon Williams, Richard H. Fenner, James K. Goodloe, Louis C. Pender.

Gates—Richard B. Gregory, John B. Baker, John Gatling.

Granville—William V. Taylor, James Ridley, James Young, Benjamin Bullock, Henry Plummer, William Nailer, I. G. Watson.

Greene—Palmer Moseley, Jno. Dobson.

Guilford—Rev. D. Caldwell, Jas. Gibson, Antwell Baily, Geo. Swain, David Worth, Marmaduke Mendenhall, John Vanstory, —— McMillan.

Halifax—John T. Clanton, Landon Clanton, R. Wilson, John Morast, T. S.

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Brorrtrow, Isaac Edwards, Major Wilcox, Jesse N. Faulcon, Geo. N. Hisslow, G. Vaughn, John H. Purvington, B. Peterson, Wm. Taylor, Richard H. Dickson.

Hertford—Thos. O'Dwyer, Lawrence O'Bryan, Isaac Pipkin, Abington Brown, A. Bardwell. Lewis M. Jiggitts.

Hyde—Hugh Jones, Andrew Shenklin.

Iredell—Joseph Guy, —— Franklin, Asa Beal, —— Osborn, —— Templeton.

Jones—Alex. Sledge, Robert Dickson.

Johnston—John T. P. Yeargain, Wilie N. White, R. H. Helme, S. C. McMillin.

Lenoir—Lewis G. Haywood, Abraham Croom, Jno. H. Parker, Chancy Graham.

Lincoln—Wm. McLean, Jas. Birrings, Wm. Johnson, —— Newland.

Martin—Jesse H. Jones, James Yellowly, John Crichlow.

Mecklenburg—Stephen Fox, James G. Porter, Robert McKenzie, David R. Dunlop, David Daw, Joseph McKnitt Alexander, Moses W. Alexander.

Montgomery—James W. Craig, John A. Wooley, James Marshall.

Moore—F. G. Henry, Kennith B. McIver.

Nash—Oliver Cushing, Asahel J. Knocelton, Lemuel Lewis, —— Pritchart, Isaac Sessums, Richard H. Archer, John Arrington, Athelston Anderson.

New Hanover—James F. McRee, Wm. J. Harris, Armand J. DeRosset, John Hill, Augustus Laland, George McMillan, James B. Larogue.

Onslow—William French, Daniel Duvall, Hugh Farrier, Harris Lumis.

Orange—John Umstead, Jas. Webb, James S. Smith, John A. Mebane, Wm Holt, Chas. Yancy, Hudson M. Cave, Barnabus O'Farrell, Thomas Faddis, —— Mitchell.

Pasquotank—Isaiah Sanstrum, Frederick Ford.

Person—Currie Barnett, Osborn Jeffreys.

Randolph—Phineas Nixon, Thomas Nixon, William Hannah, Frederick L. Henry, Joseph Wood.

Richmond—Robert Thomas, R. D. Cole, J. P. Bishop, Angus Fairly, —— Woodson, John McLeod.

Robeson—Willis Pope, William Carloss, Patrick McAlpin.

Rockingham—Edward T. Broadnax, Geo. W. Jones, John Murry.

Rowan—John Beckwith, Stephen L. Ferrand, Isaac Burns, J. Bosweth, Jos. Hilliard, Robert Moore, Joseph Mengleburg.

Rutherford—John McIntyre, Charles Selraflin, Joseph Hamilton.

Sampson——— McKay, —— Strong.

Stokes—Andrew Bowman, Frederick Shewman, Thomas Lacy, Robert W. Mosley, David Keel, Geo. Folger, Jeremy Parkhurst.

Surry—Geo. Kimbrough, Benj. Franklin, Alex. Williams, —— Hamilton.

Wake—James M. Henderson, A. S. H. Burges, Jeremiah Battle, Bazaleel Gillet, Sterling Wheaton, Calvin Jones, John Y. Young, Wm. K. Fenner, Jasper Gillet, Wm. H. Hunter.

Warren—Philip C. Pope, Stephen Davis, Wm. Broddie, Joseph Hawkins, John M. Walker, John P. Nicholson, Littleton W. Coleman, Thos. P. Jones, —— Delony, Robert Williams.

Washington—Julian Picôt, Francis Ward, Samuel Dudley, William Cokely.

Wayne—Joseph Edwards, Lewis Bush.

Wilkes—William W. Martin, Robert Church.

ANTISEPTICS AT JOHNS HOPKINS HOSPITAL.

MOUNT OLIVE, March 4, 1893.

Editors North Carolina Medical Journal:

The following are the antiseptic measures as observed at Johns Hopkins Hospital: Bichloride of mercury is no longer used, as it forms an albuminate with the tissues, and retards granulations. All dressings and bandages and clothing are sterilized, heat being the best agent to destroy germ life.

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Before all operations, the hands and arms of the operator and his assistants are (1) washed with soap and warm sterilized water and thoroughly scrubbed with flesh and nail brushes; (2) the hands and arms are next washed with a saturated solution—1 to 16—potassium permanganate; (3) from the permanganate solution they are next washed in a solution of oxalic acid—1 to 8—dissolved in boiling water; (4) hands are now washed in warm sterilized water.

All instruments are sterilized in Arnold's Steam Sterilizer for twenty or thirty minutes, or in boiling 1 p. c. solution of sal soda for five minutes. Instruments during the operation are left standing in sterilized water. The assistant hands the operator (in Dr. Kelly's operating room) all instruments with gloved hands, the gloves being of thin rubber and having been in soda solution. The following antiseptic dressing is the one in constant use:

℞.—Bismuth subiodide..... ʒ i.
Acid, boracic, pulv..... ʒ viij.
M. Sig. Apply plentifully.

The peritoneal cavity is thoroughly irrigated (3 litres) with sterilized salt solution (gr. xc to Oij) at a temperature of 110 or 112. In abdominal surgery, when a drain was required, Miculicz's was used. All operators and assistants are dressed in sterilized clothing, and all visitors are furnished sterilized dusters before entering the operating-room.

Very respectfully,

JULIUS A. FAISON.

A MONSTROSITY.

CONOVER, N. C., April 12, 1893.

Editors North Carolina Medical Journal:

On April 8th, we were summoned to attend Alice H., colored, and on arriving found her delivered of a "monstrosity," a photograph of which we enclose.

The mother is about 18 years of age, unmarried, height 5 feet, and weighs 135 pounds. Her parents are black, and give no evidence of scrofula or constitutional disease. The mother of this "monstrosity" was treated for specific disease two years ago, but at the present time shows no traces of that disease. Some time thereafter, she became insane and was sent to the North Carolina Insane Asylum for treatment. After remaining there for six months, she was discharged as cured, and at the present time her mind seems perfectly sound.

The alleged father is said to be white, and, judging from the appearance of the "monstrosity," this would seem to be the case. The two children, which, being united together, make this "freak," are fully six inches in length, and both are males. They are united from the umbilical region to the angle of the inferior maxillary bone, having one neck and two well developed heads. There seems to be two alimentary canals, one to each child.

This "monstrosity" was born in Catawba county, North Carolina.

Very truly yours,

DRS. D. MCD. YOUNT and
F. L. HERMAN.

[After consulting the authorities, and finding no parallel to this unique case, we decided to have the photograph of this "monstrosity" reproduced, in three different positions, for the benefit of the readers of the NORTH CAROLINA MEDICAL JOURNAL, so that they might the more readily comprehend its anatomical relations.—EDITORS.]

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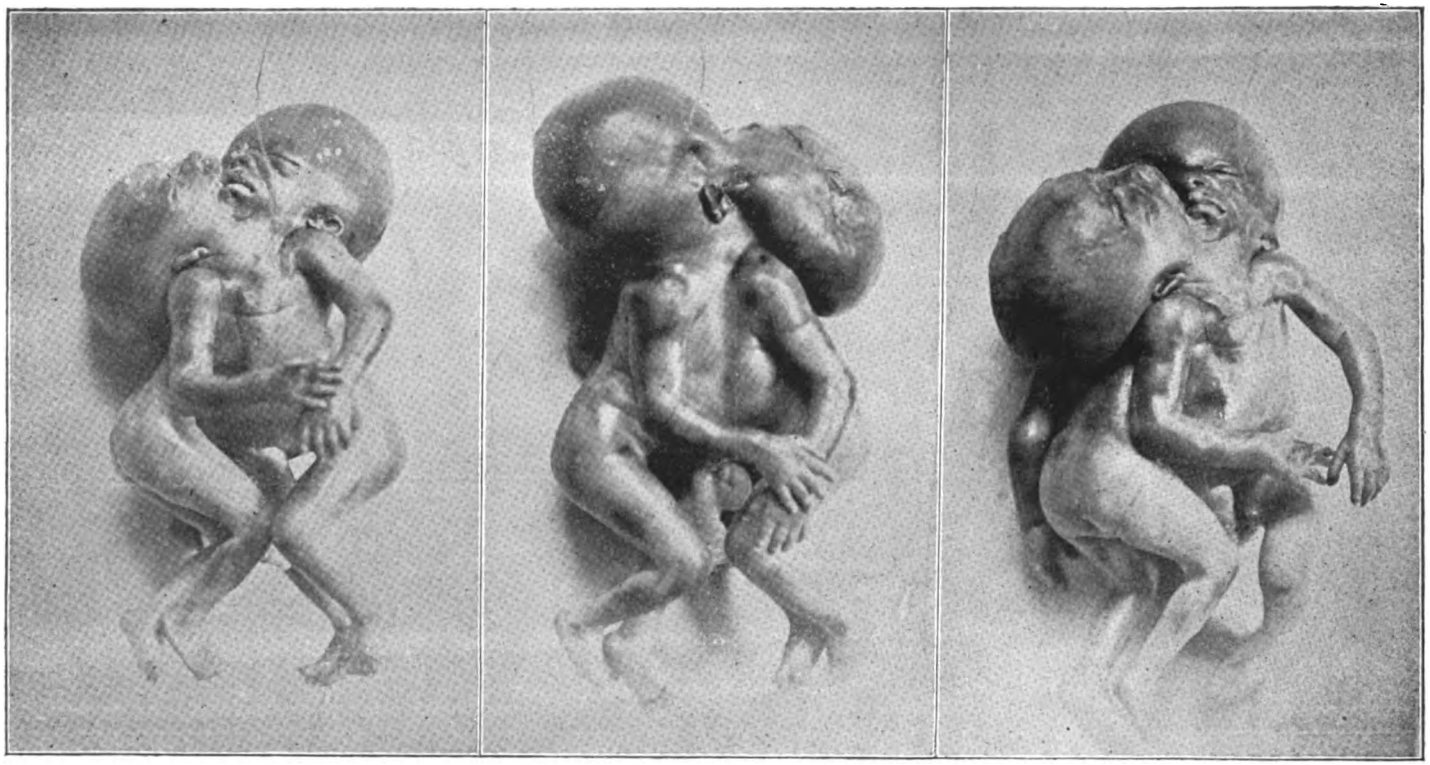

MONSTROSITY BORN IN CATAWBA COUNTY, NORTH CAROLINA, APRIL 8TH, 1893.

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Epitome of the Newer Remedies.

A READY-REFERENCE RECORD FOR THE BUSY PHYSICIAN.

In order that the general practitioner, without neglecting other important matters, may keep fully informed as to the science and art of modern therapeutics, the Editors purpose to consider briefly each month, under this caption, the most approved new remedies.

While acknowledging their indebtedness to various writers, their aim will be to omit all elaborate discussion, and to state concisely the bare essentials necessary to an accurate study and correct comprehension of the drugs named, especial attention being given to their therapeutic applications and the modes of their administration.

Upon request of physicians, any new drug that may be specified by them will be considered, or if further private information be desired concerning any one already named, it will be furnished upon application.

Only ethical preparations will be considered.

PIPERAZIN.

This drug is obtained by the action of ammonia on bromide or chloride of ethylene.

Physical Properties.—It is an unstable crystalline body, having a melting point of about 220° F. The aqueous solution is alkaline, but practically tasteless.

Solubility.—It is exceedingly soluble in water.

Physiological Action.—The administration of this drug causes an increase in the amount of urea in the urine with a decrease in the uric acid, indicating that under its influence oxidation is more complete.

Therapeutic Uses.—Up to the present time, Piperazin is the best medicament known as a solvent for uric acid and urate concretions. It is used for the purpose of preventing the formation of renal and vesical calculi in the *uric acid diathesis*, and also in cases where the excess of uric acid in the urine tends to produce *irritation of the bladder*. It is, also, a most invaluable remedy in gout, rheumatic arthritis, and other similar affections.

Administration.—The dose is 15 grains in twenty-four hours. It is best given by dissolving this amount of the drug in one pint of water, and directing a wineglassful frequently during the day. Owing to its unstable character when exposed to the air, its attracting water and carbonic acid, the drug should be freshly mixed each day. *Opinions:* Squibb's *Ephemeris* states that it "has had an extended and almost uniformly successful year." Prof. Hare, however, up to the date of the issue of his last volume of *Practical Therapeutics* (1892), had "failed to obtain any results from the use of this drug."

LYSOL.

This substance is obtained from tar oils by boiling with alkalies and fats.

Physical Properties.—It appears as a brownish, clear, oily fluid, smelling somewhat like creasote.

Solubility.—It is soluble in water, alcohol, chloroform and glycerine.

Therapeutic Uses.—It is used as a general antiseptic in surgery and gynecology. Experiment shows it to be possessed of marked antiseptic power, and it is far less poisonous than carbolic acid. It renders the solution a little soapy, which causes the smaller instruments to be slippery, but otherwise there is no objection to it. The hands of the operator are made soft and flexible. The drug has been found of value in diseases of the skin, particularly in lupus. It is also used in diphtheria, and as a gargle for foul breaths. As an antiseptic, it is inferior to carbolic acid, but as a microbicide, it is superior and very cheap, hence it will be used largely in the prophylaxis and arrest of epidemics for disinfecting purposes.

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Administration.—Lysol is used locally in solutions of the strength of from 3 to 5 per cent.—upon mucous membranes the solution should never be stronger than 2 per cent., otherwise they may be irritating or caustic.

—

SALOL.

A compounnd of 60 parts of salicylic acid and 40 of carbolic acid.

Physical Properties.—The drug is a white, crystalline, tasteless powder, having a slight aromatic odor.

Solubility.—It is insoluble in water, but soluble in alcohol, ether, turpentine, sandalwood oil, copaiba balsam, and the fixed oils.

Physiological Action.—On mucous membranes, it acts as an irritant; on the nervous system, in medicinal doses, it exerts comparatively little effect, sometimes it causes a buzzing in the ears; on the circulation, it has rather a depressant effect; on the temperature, it acts as an antipyretic. It gives to the urine an olive-green tint, which, under long-continued use, becomes black-green.

Therapeutic Uses.—Anti-rheumatic, antiseptic and antipyretic. It has been largely used as a substitute for the salicylates in the treatment of rheumatism.

Internally.—In doses of from 5 to 30 grains, daily, it is preferable to salicylic acid in muscular rheumatic affections, because it is less irritating to the stomach. From the composition of the drug, as noted above, it is readily seen that it must not be exhibited in too large doses, for, in every hundred grains of salol, there are forty grains of carbolic acid. It is also used in diseases of the urethra and bladder, such as gonorrhœa, cystitis and others, to produce asepsis of the urine. Its solubility in copaiba, etc., renders it especially useful in prescribing it with these remedies in certain diseases of the genito-urinary apparatus. It is of very great value, too, in functional disorder of the intestines, such as in cases of *intestinal indigestion* and *fermentation*, especially when *diarrhœa* is consequent, on account of its rendering the canal antiseptic, and thus removing the cause of the diarrhœa.

Externally.—Employed, like iodoform, as an antiseptic powder, also in connection with aromatic tinctures as an antiseptic mouth-wash.

Administration.—It is best administered in capsules, or suspended in milk.

Contra-indications.—In all cases of renal inflammation of acute type.

PRESCRIPTIONS.

In *cholera morbus:*

℞.—Saloli..... 3 i
Bismuth, subnitrat... 3 ij
M. Mist. cretæ..... ℥ iij
Sig. Two teaspoonsful every 2 hours.

℞.—Saloli.....gr. lxxx
Ol. menth. pip... ♏ ij
Ol. rosæ.....♏ iij
Tinct. lavand., co. 3 ij
M. Spirit., dil., q. s., ad ℥ iij
S. Mouth-wash.

This is probably the best mouth wash in existence to-day for the preservation of the gums and teeth.

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Practical Notes of Practice.

Cocaine, in the treatment of the morphine habit, should never be used hypodermically.

Tar Tablets, containing a grain of pure tar, make a convenient way of administering this practical, and often very beneficial, remedy in coughs.

Persistent Hiccough is often controlled and relieved by the vomiting produced by hypodermic injections of pilocarpine, the diaphragm being relaxed.

Bright's Disease, Semmola says, as a result of forty-two years experience, is best treated by milk. Milk is at the same time the typical food for this condition.

Pilocarpine, in doses of $\frac{1}{3}$ to $\frac{2}{3}$ of a grain daily, has given some brilliant results in the treatment of spasmodic croup. The above dosage is intended for a child beyond one year of age.

Padded Splints will often give great relief from pain in case of rheumatism; but care must be exercised that they are not kept on too long. As soon as the inflammation subsides, motion must be made.

Strophanthus has been employed recently in exophthalmic goitre with good results. The thyroid diminished as well as the exophthalmos. It must be exhibited in large doses, eight to ten drops thrice daily—in some cases, it has been carried as high as twenty or thirty drops.

In incontinence of urine in childhood, Dr. J. E. Powers recommends the use of collodion. The prepuce is drawn over the glands and collodion is smeared on by means of a camel's-hair pencil. In contracting it draws the edges of the prepuce closely together, effectually sealing the passage. A patient after one lesson can apply it himself. A cure usually results in a couple of weeks.

Antifebrine, in five grain doses, is now much lauded for its virtues in epilepsy. We have witnessed one case that was notably improved by its use, after the usual bromide treatment had failed.

In dysentery, diarrhœa and similar complaints, especially in those cases of acute dysentery of typhoid character, Dr. E. W. Watson reports in *Therapeutic Gazette* very satisfactory, even wonderful, results from the employment of creolin. He uses exclusively large enemata of water containing creolin, one drachm to the pint, and for children one-half this strength. But one or two treatments are necessary, even in aggravated cases, which the writer reports in full.

The following are some recent suggestions in treatment—compiled from *The Universal Medical Journal:*

ACUTE CHOREA.

General Treatment. Rest in bed for 7–10 days, with isolation. Good nourishment; child to be fed by the nurse; *Ext. of malt* is valuable adjunct to diet. Wash whole body daily with soap and warm water, follow up by general massage for 20 minutes, combined with *sweet almond oil* inunction. Remove any source of nervous disturbance (constipation, worms, menstrual troubles, etc.). *Liquor arsenicalis* best remedy for ordinary cases, given well diluted, after food, and gradually increased up to ♏x–xij; especially useful in anæmic and badly nourished. In more chronic cases, give course of *codliver-oil* and *malt.*

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SYMTOMATIC TREATMENT.

FOR ACUTE PROFOUND PROSTRATION. Give *alcohol* promptly in full doses, never less than ʒ iij, often up to ʒ vj, sometimes more, in course of 24 hours. Warm wet-sheet packs (repeated sufficiently often to excite free action of skin) and brisk aperient. Rectal feeding, if necessary.

FOR CONSTIPATION. At first give dose of *castor-oil*; if constipation persist, give daily morning dose of *confection of senna and sulphur* (equal parts), or of *brimstone and treacle, comp. liquorice-powder, cascara sagrada*, or equal parts of *glycerin* and *decoction of aloes* for older patients.

FOR DELIRIUM. If from nervous exhaustion (loss of sleep), give good food, moderate supply of *alcohol*, and hypnotics. If from brain disorder (insanity, hysteria, etc.), same treatment as preceding. If result of auto-toxæmia in connection with acute prostration, treatment of latter condition as above given.

FOR PARALYSIS. Local hypodermatic injections of *liq. strychniæ*, ♏ j; faradism; massage.

FOR SLEEPLESSNESS. In mild cases, give hot sponge-bath at night, followed by cup of warm milk food containing small quantity of *brandy*. Quiet, darkened room, ventilation, cool temperature, comfortable arrangement of bed and bedding. *Potass. bromide* with *chloral hydrate*, aa gr. x–xx. If concurrent rheumatism, full doses of *sod. salicylat.* instead of *arsenic*, and add *laudanum*, ♏ v–x to the *chloral and bromide* draught. If wild, maniacal excitement (insanity, hysteria) give hypodermatic injections of *hyoscine hydrobromate*. gr. 1-100, closely watched; *chloral* is not admissible if profound general prostration. *Chloralamid* or *paraldehyde* in some cases. *Sulphonal* useless by itself; may prolong effect of a *chloral* draught when given 2 hours before, partially dissolved in brandy and hot water. *Chloral* also used in successive doses to keep patient asleep for several days to break up choreic habit; occasional intervals of waking for giving food.

CHRONIC CHOREA.

Massage, Swedish exercises, amusements, nutrition, personal hygiene of patient. (Alfred H. Carter, *Provincial Medical Journal*, February 1, 1893.)

CONSTIPATION, CHRONIC.

Dilatation of the sphincter ani. Abdominal massage. Electricity to be applied by the physician. Patient should go to stool daily at same hour; correct errors in diet; exercise (out-door); dress warmly in winter; take glass of cold or warm water on rising in morning, or eat fruit at beginning of morning meal; make change in climate or occupation if necessary. (S. G. Gant, *Medical Herald*, March-April, 1893.)

ECLAMPSIA.

Inhalations of *oxygen*, regulating the quantity of gas given by the condition of the urine. If the only alteration is the presence of a small quantity of albumen, give 30 litres (quarts) during the 24 hours. If the amount of organic depuration is below the physiological standard, double or treble this amount is given. (Jaccoud, *L'Union Médicale*, February 9, 1893.)

FRACTURE.

COMPOUND COMMINUTED, OF HUMERUS.

Freely pare edges of wound, irrigate with *sublimate solution*, and bring edges together with silk sutures; no drainage-tube. *Cyanide* dressings. Envelop limb in *plaster of Paris*. Not dressed for two weeks. Leave off splint at end of month. (Bidwell, *Brit. Med. Jour.*, March 18, 1893.)

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PERTUSSIS.

℞. *Beech-wood creasote* (gr. iv); *sulphonal* (gr. iij); *syr. tolu* (℥ v). M. Sig. Teaspoonful every two hours. (Almeida, *Pharm. Post.*, No. 4, 1893.

PRURITUS VULVÆ.

℞. *Potass. bromidi, lupulini*, aa (gr. xxx); *hydrarg. chloridi mit.* (ʒ iis); *ol. olivæ* (℥ j). M. Sig. For external use; shake well before using. (Meisel, *Les Nouveaux Remèdes*, February 24, 1893.)

PUERPERAL FEVER.

Prophylaxis. Hands of attendant should be surgically clean, bed freed of all blood-staining, any fragments of membrane or placenta removed by careful syringing with sterilized water, with or without antiseptic drug in solution, especially if labor has been protracted. Repair at once any laceration of perinæum and dust with *iodoform*. Vaginal syringing daily; if suspected cervical laceration, much loss of blood, prolonged labor, dead child, or in unhealthy subjects.

Treatment. When septic fever has occurred, give mixture of *ergot* and *iron*. Rinse out vagina, flush uterus by means of flushing curette, aided by speculum and tenaculum forceps, and then leave *iodoform suppository* within the uterus. Insufflate *pulv. ac. boracic* and *iodoform* into upper vagina and on to the os, to be repeated, if necessary; in other cases simply continue vaginal syringing. (W. T. Clegg, *Prov. Med. Journal*, February 1, 1893.)

SELECTED FORMULÆ.

Prof. Hare gives the following formula for the use of quinine hypodermically:

℞.—Quininæ hydrochlorat..gr. vij
Glycerini,
Aquæ destillat., aa.....ɱ xxx
M. Sig. Warm the solution before using.

The following prescription is recommended in cases of pruritus vulvæ:

℞.—Hydrarg. chlorid. corrosive.....gr. ½
Acid. hydrocyanic dilu..f ʒ j
Aquæ amygdal. amaræ..f ℥ j
M. Sig. Apply to itching parts.

For Anemia with Constipation:

℞.—Extracti nucis vomicæ..gr. ¼
Ferri sulphatis exsiccatæ.gr. j
Aloin.....gr. ¼
Pulveris myrrhæ
Pulveris ipecacuanhæ, aa. gr. ss
Extracti gentianæ.....gr. ij
Misce et fiat pilula.
Sig. To be taken every night.

For Sore Throat:

The following is recommended in the treatment of sore throat:

℞.—Cocainæ hydrochlorat.grs. viij
Acid. carbolici.....ʒ i
Glycerinæ.....f ʒ iv
Aquæ rosæ q. s., ad....f ℥ xii
M. Sig. To be diluted with an equal quantity of water, and used alternately as a spray and gargle.—*Med. Progress.*

For Cystitis in Women:

℞.—Citrate of potassium.....℥ ss
Fl. ext. triticum repens,
Tinct. belladonna,
Fl. ex. buchu, aa....℥ ss
Water, add to make 4 ounces.
M. Sig. A teaspoonful in a wineglassful of water three times a day.

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NORTH CAROLINA MEDICAL JOURNAL.

ROBERT D. JEWETT, M.D.,
J. ALLISON HODGES, M.D., } Editors and Proprietors.

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Secretaries of County Medical Societies in the Carolinas are asked to furnish condensed reports of their meetings to the JOURNAL.

Remittances should be made by P. O. Order, Draft or Registered Letter, payable to the NORTH CAROLINA MEDICAL JOURNAL.

All communications, either of a literary or business nature, should be addressed to the NORTH CAROLINA MEDICAL JOURNAL, P. O. Drawer 810, Wilmington, N. C.

Editorial.

THE ANNUAL MEETING OF THE SOUTH CAROLINA MEDICAL ASSOCIATION.

It was our pleasure to attend the recent meeting of the South Carolina Medical Association, held on April 19th and 20th at Sumter.

This privilege of visiting this charming city and noting its increasing evidences of growing thrift and prosperity, and at the same time of mingling with her hospitable citizens and the representative physicians congregated there, was greatly enjoyed by us.

Capt. W. R. Delgar, on behalf of the citizens of Sumter, made an address of welcome, which was responded to by the President of the Association, Dr. W. H. Nardin.

The first day's proceedings consisted of reports of surgical cases by Dr. Manning Simons; of cases of abdominal section, by Dr. W. F. Strait; of cases from practice, by Dr. G. K. Dean, and a paper upon Purulent Ophthalmia, by Dr. C. W. Kollock.

In the evening, a masterly address was delivered by Dr. H. O. Marcy, of Boston, the annual orator of the Association, upon "The Surgical Treatment of Hernia." The address was illustrated by pictures thrown against the wall with a powerful stereopticon, under the management of Prof. Savastano.

The morning hour of the second day was occupied by an address before the Confederate Survivors' Association of Surgeons by Col. James Armstrong, of Charleston. It was an earnest and patriotic speech, and was delivered with the speaker's inimitable grace and eloquence.

Following this, a most interesting and instructive report on the recent improvements in obstetrics was made by Dr. P. G. De Saussure, Professor of Obstetrics and Gynecology in the South Carolina Medical College; then came many other interesting papers, among them, The Successful Transplantation of the Conjunctiva of a Rabbit to the Human Eye, Dr. F. L. Parker; Ophthalmia, by Dr. George Howe; Aphasia, Following De-

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livery, by Dr. A. A. Moore; Paralysis of the Fauces from Bulbar Disease, and Bilateral Paralysis of the Adductors, by Dr. Walter P. Porcher; Syphilitic Manifestations in the Eye and Throat, by Dr. E. F. Parker; and Hypertrophy of Faucial and Pharyngeal Tonsils, by Dr. W. J. Garner.

The special prize offered by Professor Joseph Price, of Philadelphia, for the best essay on "The History of Surgery in South Carolina," was unanimously awarded by the Committee to Dr. E. F. Parker, of Charleston. This essay was read before the Association, and its author was highly complimented upon the research and erudition displayed in its preparation.

A second prize, offered by Dr. H. O. Marcy, for the next best essay, was awarded to Dr. L. C. Stephens, of Blackville.

All of the papers presented at this meeting were of a high order of merit, and reflected much credit upon the profession of our sister State. Their preparation evinced much original research, and clearly demonstrated that the medical faculty belonging to this Association are in the fore-front of medical progress.

The following officers were elected for the ensuing year:

President, Dr. John L. Ancrum, of Charleston.

First Vice President, Dr. James C. Willcox, of Darlington.

Second Vice President, Dr. A. J. China, of Sumter.

Third Vice President, Dr. Thomas P. McCoy, of Laurens.

Corresponding Secretary, Dr. M. P. Ravenel, of Charleston.

Recording Secretary, Dr. W. P. Porcher, of Charleston.

Treasurer, Dr. Charles M. Rees, of Charleston.

The Association adjourned to meet in Rock Hill on the fourth Wednesday in April, 1894.

It is almost needless for us to say that Sumter's hospitable physicians and citizens made the concluding event of the meeting its crowning one, so far as the social pleasures were concerned, for all will agree that the banquet was a most elegant and superb entertainment. If the Old North State, on that occasion, did not respond, both in sentiment and in spirit to the demands of the hour, the blame must rest where it rightly belongs, upon the generous hosts and their excessive hospitality in dispensing *lithiated* tonics in too profuse an abundance.

The evening was a most enjoyable one, and will long be remembered as one of the most pleasant incidents of our visit to the Game Cock City.

THE MEDICAL PROFESSIONS OF NORTH AND SOUTH CAROLINA WILL NOW "SMILE" TOGETHER.

It is with great pride that the NORTH CAROLINA MEDICAL JOURNAL now makes the announcement that it was made the *official organ* of the South Carolina Medical Association, at its recent meeting in Sumter, by a unanimous vote of its members.

The profession in North Carolina, we are assured, will join with us in returning thanks to our distinguished confrères for this high compliment and renewed evidence of fraternal regard.

Allied together by so many bonds of friendship and loyalty in the past, this new evidence of a union of hearts and of hands and of minds in upbuilding and elevating our common profession in the South, will be hailed with great delight. As the Governor of South Carolina once said to the Governor of North Carolina: "Brothers, let us smile."

TREATMENT OF TYPHOID FEVER

Since the cause of typhoid fever has been demonstrated to be the bacillus described by Eberth and Klebs, and

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later by others, the attention of physicians have been directed to the remedies which possess antiseptic properties as being a rational method of treatment.

Chiefest in this class, and each of which has its enthusiastic advocates, are calomel, salol, nitrate of silver, sulphocarbolate of zinc, iodine and carbolic acid, oil of turpentine and chlorine water. With each of these different observers claim to have had excellent results.

Oil of turpentine has long held an important and a deserved place as a useful agent in the treatment of this disease, and probably no one has failed to note the prompt improvement from its employment in those cases where the tongue is brown and dry, where there is a tendency to sordes, and where the abdomen is markedly tympanitic. It is best given in emulsion, in doses of five to ten drops, or the white turpentine may be given in capsules two or three grains to the dose. The following formula makes a good emulsion:

℞.—Oil of turpentine.....oz. ss.
Tragacanth.....dr. ss.
Syrup.....oz. j.
Water to make.....oz jv

To the oil of turpentine contained in a dry bottle, add the tragacanth and shake; add one fluid ounce of the water and agitate vigorously. Then add the syrup in portions, shaking after each addition, and finally, in portions, enough water to make four fluid ounces, shaking well after each addition.

In an article on Typhoid Fever, by Professor William Pepper, in An American Text-book of the Theory and Practice of Medicine, the author expresses his preference for nitrate of silver over all other antiseptics. It is best given in the following pill:

℞.—Argenti nitratis.....gr. vj.
Ext. opii,
Ext. belladonnæ, aa.....gr. ij.
Mannæ.....q. s.
M. et div. in pil. xxjv.
S. A pill 3 times a day soon after food.

Or, if the stomach is irritable, it may be given freely diluted—two grains to three or four ounces of water—a teaspoonful every four or six hours on an empty stomach. In administering the pill, if there is too much tendency to diarrhœa, the belladonna may be omitted and the opium increased; or, if the bowels are rather constipated, the opium may be omitted and one-sixth of a grain of extract nux vomica may be added to each pill.

Professor Yeo, in a lecture on the Antiseptic Treatment of Typhoid Fever, which appeared in the JOURNAL in full in the issue of June, 1891, claims most satisfactory results from the administration of chlorine water with small doses of quinine. His experience with it in a number of consecutive cases was always satisfactory, and he claims for the treatment the following facts:

1. A modification and sustained depression of the febrile temperature.

2. An abbreviation of the average course of the fever.

3. A remarkable maintenance of the physical strength and intellectual clearness of the patient, so that there has been far less need for stimulants.

4. A greater power of assimilating food.

5. A remarkable cleaning of the tongue.

6. A deodorization of the evacuations.

7. A more rapid and complete convalescence.

The chlorine gas is made as needed by the addition of forty minims of strong hydrochloric acid to thirty grains of chlorate of potash in a 12-ounce bottle, water being gradually added to fill the bottle, shaking well after each addition To this is added 24 to 30 grains of quinine and an ounce of syrup of orange-peel, and an ounce is administered every two, three or four hours, according to the severity of the case.

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That the administration of antiseptics does materially influence the course of the disease, cannot be denied in the face of the affirmative reports of careful and trustworthy observers, which show a marked falling off in the death-rate as compared with that before the researches of the bacteriologist made clear the true nature of the disease.

But, while recognizing the importance of drug treatment, the fact remains that it is seldom that a case of typhoid fever fails to run its course as regards time. This leads us to the prominent position held by the dietary and hygienic treatment in the successful management of this malady. Probably in no other disease does a patient lie for so many days, as is sometimes the case with this, at the very brink of the grave, and then have the balance turned in his favor and be restored to health. And in this disease especially may it be said with truth that a good nurse and no physician is better than the best physician and an ignorant and careless nurse. If there be a better ventilated and more comfortable room in the house than that in which the patient is taken sick, he should be removed to it as soon as the nature of his disease is determined. Every effort should be directed toward nourishing and sustaining the strength of the patient, so that he may be the better able to resist the disease and be in the best condition possible when convalescence commences, that his return to health may be the more rapid.

The question of feeding has been much discussed with the generally accepted conclusion that milk is the food *par excellence* for a typhoid fever patient, as being liquid, highly nutritious and furnishing a minimum amount of debris to irritate the diseased intestines. But there are instances when it is objectionable on account of the patient's aversion, its tendency to cause constipation, or the patient's inability to digest it in sufficient quantity. When these objections cannot be met by scalding the milk, the addition of lime-water or barley-water, or by partial predigestion, it may be substituted, in part, or altogether, by whey, butter-milk, koumyss, or some of the many excellent prepared foods upon the market. If broths and meat teas are depended upon, it should be borne in mind that they are rather stimulants than foods, and they should be reinforced by some of the beef extracts or liquid peptonoids.

The question of stimulation by alcohol is a much vexed question, and one which deserves careful consideration at the hands of the profession. That there are cases in which no stimulation is indicated from first to last is evident, and it is the routine administration of alcohol in just such cases that has led to the censure of the profession as being responsible for the intemperance of some of their patients. But there are other cases in which the administration of stimulants is absolutely necessary, and when such a case arises the conscientious physician will not allow his judgment to be swayed by prejudice or the fear of public criticism. There are cases in which alcohol is required, even in enormous quantities, to carry the patient through the crisis of his sickness; but it is a part of the treatment for which no set rules can be given. Each case must be a law unto itself, and the physician be guided by the condition of the pulse, which should be carefully watched.

On the introduction of the coal-tar derivatives, their power to reduce temperature in fever led to their excessive use in typhoid fever, but they were given too indiscriminately and in too large doses, so that they are losing favor, and are now, by some writers, considered out of place here. They are sometimes useful, however, in small doses, for the relief of nervous irritability. When used at all for the reduction of temperature,

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it should only be when the pyrexia reaches 103° F., and then they should be given in only small doses, that will effect a reduction of one or one and a half degrees.

Since the remarkable results obtained by Brand with his cold bath treatment, the profession have been making more and more use of hydrotherapy, though but few have ventured to carry out Brand's method as vigorously as he advocates. Those who have used only the milder methods of applying water must have seen its beneficial effect in the reduction of the temperature and the alleviation of the distressing nervous symptoms. How often have we seen a patient who had been tossing about in his restlessness, wasting his own strength and, taxing the patience of his nurse, fall into a refreshing slumber after a simple sponge bath of cool water and vinegar! Brand has tabulated 1,223 cases treated with cold baths by himself and others, in which the mortality was only *one per cent.*; and while the general statistics under the bath treatment do not present so low a death rate, the fact remains that under no other method have such favorable results been obtained.

The reduction of temperature is not the only good effect of this method. Even in those cases in which the baths fail to reduce the temperature, their usefulness is seen in the general improvement of the patient's condition. The whole course of the disease is rendered milder, there is less restlessness and sleeplessness, so that convalescence is more rapid, and there seems to be less tendency to hæmorrhage, dangerous complications and relapses.

THE CAPE FEAR QUARANTINE STATION.

While there has been for some years a quarantine officer, in the person of Dr. W. G. Curtis, stationed at Southport, formerly Smithville, there has been a quarantine station only in name. We are glad to note, however, that under the stimulus of a threatened invasion of our country by cholera, the last Legislature listened to the earnest appeal of the Quarantine Board and appropriated the sum of $20,000 to be used in the erection of suitable wharves and buildings for separating and caring for the sick and well persons, upon infected vessels coming to this port, the city of Wilmington augmenting this amount by $5,000.

The appropriation by the Legislature was made with the provision that it was to be used only when, in the opinion of the Governor and the State Board of Health, there should be imminent danger of the introduction of an epidemic disease.

At a recent conference of State health officers and quarantine physicians in the city of New York, a resolution was adopted setting forth the importance of having all ports of entry at once put in a condition to properly care for any infected vessel that may seek entrance into this country. In view of this action and the fact that reports show a regular increase in the number of cases of cholera in Europe, the State Board of Health and the Governor have decided that the Cape Fear Quarantine should be made as efficient as possible, and have notified the Quarantine Board that the appropriation is accessible at any time.

The Quarantine Board have selected a site for the station one mile and a quarter above the city of Southport, which is immediately at the mouth of the Cape Fear, and upon the opposite side of the river. Plans are in course of preparation, and, as soon as adopted, bids for building the station will be invited and the work rapidly pushed to completion.

This is a very important work and one in which the whole State is vitally in-

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terested, or should be; for, while the city of Wilmington is most directly concerned, she has five lines of railroad radiating into all sections of the State, and the admission of an epidemic disease into this city means also the dispersion of the disease into all parts of the State by her citizens in their efforts to escape from the pestilence.

We heartily approve the wisdom of the Legislature in making this appropriation, and congratulate the State upon this great step in the way of progress and in the protection of the lives of her citizens.

THE PAN-AMERICAN MEDICAL CONGRESS.

The Pan-American Medical Congress will meet in Washington, D C., September 5, 6, 7 and 8, 1893. The President is William Pepper, M.D., Philadelphia, Pa.; Treasurer, A. M. Owen, M.D., Evansville, Ind.; Secretary General, Charles A. L. Reed, Cincinnati, O.

The work of the Congress will begin, in the various sections, September 5, and will close September 8, 1893.

In a communication from Dr. H. A. Hare, President of the Section on Therapeutics of the Pan-American Medical Congress, he desires us to state in these columns that it is the earnest desire of the officers of the Section on Therapeutics of the Pan American Medical Congress that both specialists and general practitioners should contribute articles to its proceedings.

Gentlemen who desire to read papers at this meeting should notify Dr. Hare at once of their intention, and should send him, by July 10th at the latest, an abstract of their paper, in order that it may be translated into the three official languages of the Congress and published in the programme. The importance of this Section and the interesting papers which have already been promised, give assurance of a very successful meeting.

The Section on General Medicine, which is one of the most important that has been created, bids fair to be one of the most successful in the entire Congress; and already many valuable papers are in process of preparation, and will be read at the meeting.

It is especially requested that those intending to join the Section on General Medicine, or to read papers, shall at once send their names, with titles of papers, to the Secretary, Dr. Judson Daland, 319 South Eighteenth Street, Philadelphia.

SPECIAL PREMIUM OFFER.

The missing word in the April issue was "*periodical*," and was not supplied in any of the numerous answers we received.

We will offer to the first paid-up subscriber who supplies the correct missing word on page 239 of this issue, in the reading notice of Messrs. Renz & Henry, a copy of the *International Medical Annual* for 1893. To the next five we will mail a clinical thermometer, with lens front, gold-plate case and chain and certificate. To all who take the trouble to respond, whether answer be correct or not, will be sent a hard-rubber pen holder. Answers received on and after May 20th.

NORTH CAROLINA BOARD OF HEALTH.

The Governor has appointed the following named gentlemen as members of the State Board of Health, to serve two years: Dr. W. H. G. Lucas, of Bladen, to succeed Dr. J. H. Tucker, of Henderson; Prof. F. P. Venable, of Chapel Hill, to succeed himself; Mr. J. C. Chase, C. E., of Wilmington, to succeed Mr. J. L. Ludlow, of Winston.

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Miscellaneous Items.

Under this head space will be given, free of cost, to those *paid-up* subscribers who desire to change their location, or to dispose of practice or property. One insertion will be allowed, but inquiries must not be ordered addressed to this office.

Any news connected with professional men and matters in North and South Carolina will be appreciated by the Editors.

Dr. D. I. Watson has just been re-elected to the Mayoralty of Southport.

We regret to announce the death of Dr. William Battle, of Lilesville, N. C. Dr. Battle was brother to Mr. Richard H. Battle, of Raleigh, and Dr. Kemp P. Battle, of Chapel Hill, N. C.

FOR SALE.—One Roberts & Allison Physician's Office Chair. Been used but very little. For terms and particulars apply to A. McKINNON, M.D.,
Chadbourn, N. C.

The Queen of Corea maintains a lady physician, who is accommodated with apartments in the royal palace, and receives a yearly salary of $16,500. She is obliged to visit the Queen every day, and remain within call when her Majesty is indisposed.

Dr. Andrew H. Harriss, of this city, has just graduated at the Medico-Chirurgical College of Philadelphia, winning the first place and receiving honorable mention in all branches. Dr. Harriss passed his examination before the State Board in 1892.

There was quite an interesting trial at Thomasville a few days ago. A doctor, who seemed to be making some wonderful cures with electricity and charcoal, was indicted for practicing medicine without license. He was bound over to court, because it appeared in evidence that he had prescribed, or recommended, charcoal, and one witness testified that charcoal was a drug. So says the High Point *Enterprise*.

Dr. R. J. Brevard has been re-elected Mayor of the city of Charlotte.

In the graduating class of 179 members of the College of Physicians and Surgeons of Baltimore, the following are from North Carolina: Daniel G. Beckwith, William D. Bowen, Francis M. Clarke, James L. Doughton, Albert J. Eller, C. F. Griffin, David J. Hill, W. Lee Hill, C. Cushing Jackson, J. Loftin Kernodle, James W. Kornegay, Jesse F. McCracken, Charles B. NcNairy, Wm. B. Moore, W. James Moore, Thomas M. Riddick, Edgar E. Rollins, M. Eugene Street, Charles B. Walton, A. Miller Whisnant, Frank W. Whitehead, Charles T. Windley, Charles I. Wyche.

THE WORLD'S CONGRESS AUXILIARY OF THE WORLD'S COLUMBIAN EXPOSITION.—The Congress of Medico-Climatology will convene in the Art Building in Chicago May 29th, continuing one week. A choice programme has been arranged, and many of the most noted climatologists have already promised to be present. This Congress promises to be one of the most interesting that will meet during the World's Fair Year. Thursday, June 1st, has been appointed a Field Day for the discussion of the causative and curative relations of Climates to Consumption. Reports from all parts of the world will be presented. All physicians are cordially invited to be present.

J. A. ROBINSON, M.D.,
T. C. DUNCAN, M.D.,
L. B. HAYMAN, M.D.,
Programme Committee.

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Reading Notices.

INTERVIEW WITH A PROMINENT PHYSICIAN.

Q.—Doctor, what discoveries and improvements for the treatment of Syphilis have been made in the past two or three years?

A.—None.

Q.—None?

A.—No, I mean in the way of "new" remedies, but only in the way of our better knowledge of handling old and well-known remedies. For example, your Elixir Three Chlorides, R. & H., is a perfect chemical and therapeutic combination—one of the most potent agents in my hands known. Yet it contains no new drugs.

Q.—Do you administer Elixir Three Chlorides, R. & H., according to directions?

A.—Generally, yet I prescribe it in Q. S., i. e., *ad libitum*.

Q.—Have you ever developed toxic symptoms from either of the Arsenic or Mercury?

A.—Never.

Q.—Do you consider the dose as per combination and directions large enough to meet requirements and conform to your ideas of quantity?

A.—Singularly, No, *but* combined there is a mutually synergistic action—which is not only surprising, but convincing.

Q.—What do you think of Elixir Three Chlorides, R. & H., as a vehicle for Kali-Iodide, as a preventor of Coryza and Gastric disturbances?

A.—Will answer that question on further trial.

Q.—What do you know of Elixir Three Chlorides, R. & H., as a general tonic in Anæmia, Chlorosis and that symptomatic trouble, Amenorrhœa?

A.—In these troubles it is worthy to be called a sheet-anchor. You are certainly right in speaking of Amenorrhœa as a symptom, or symptomatic trouble.

Q.—Then I take it you do not approve of Specifics, so-called, or Emmenagogues?

A.—They are a delusion and a fraud.

Q.—Why so?

A.—Answer that question yourself. What is the most rational and sensible view to take of the Etiology of Amenorrhœa?

Q.—Well, if you put it in that way, I should say, first, we have an impoverished condition of the blood and an insufficient quantity; as a result a diminished blood-pressure and blood stimulus, and the function is thus suppressed, I might say, in protection of the patient.

A.—Exactly. Now let the Uterus and ——— alone. They have nothing to do with it, and direct your efforts to building up the blood, and through it tone up the nervous system, and the menstrual function will re-appear as a natural sequence, and amongst a few good things I know nothing better than your Elixir Three Chlorides, R. & H.

Q.—Of what service do you find Elixir Three Chlorides in Dermatological practice?

A.—Theoretically, it is a good combination, and practically, I have not been disappointed. I rely upon it as one of my standbys. The Iron and Calisaya Alkaloida are feeders and tonic, while the province of the Arsenic and the Mercury is to well known to require discussion.

Q.—On the whole, do you consider Elixir Three Chlorides, R. & H., a good standard preparation and worthy of the confidence of the profession?

A.—Most assuredly—Yes.

Pepsin is undoubtedly one of the most valuable digestive agents of our Materia Medica, provided a good article is used. Robinson's Lime Juice and Pepsin, and Arom. Fluid Pepsin we can recommend as possessing merit of high order.

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ARISTOL IN HEMORRHOIDS.—To establish a radical cure, all causes to be ascribed to a faulty diet, strong drinks or want of exercise, must first be removed. Then every morning and night, and in severe cases every three or four hours, about one ounce of cold water is injected into the rectum and allowed to remain as long as possible. Morning and night the following suppository is applied:

℞.—Extracti opii.....grs. iij
Extracti belladonna..gr. j
Quinia muriat.....grs. xxxvj
Ergotin.....grs. xviij
Aristol .....zj
Olei theobron,
Ceræ albæ, aa q. s. et
fiant suppository. No. vi
Sig. One morning and night.

Immediately after each movement of the bowels, the following salve spread over the point of the index-finger is pushed up into the rectum for about one and a half inches, and some upward pressure is exerted by the external sphincter:

℞.—Unguent zinci benzoat..zj
Balsam, Peruvian... ...zj
Aristol.....grs. xxx
M. Ft. unguent.
Sig. Externally.

While internally from one to two heaped teaspoonfuls, in plenty of water, are taken two or three times daily of the following powder:

℞.—Sulphur, flor.,
Potass. bitartrat, aa.....zij
M. Pt. pulvis, S.
——— ENGLE, *Medical Summary.*

DR. ALBERT RITTER VON CHRZASCZEWSKI, of Sambros, Galicia, Austria, on November 28th, 1892, writes: Bromidia is superior to all other hypnotics, and is free from all unpleasant effects.

DOING ALWAYS BETTER WORK THAN EXPECTED.—I have used SANMETTO, and I find it does all that is claimed for it. In all the cases in which I have used it I find SANMETTO has worked wonders, doing always better work than one would reasonably expect.

Elsie, Mich. A. B. WAY, M.D.

I find Peacock's Bromides of great service in Uterine Congestion. JOHN MATHER, L.F.P.S., Haddington, Laboratory, Haddington, Scotland.

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INGLUVIN.

A POWDER:—PRESCRIBED IN SAME MANNER, DOSES AND COMBINATIONS AS PEPSIN; USED IN ALL CASES WHERE PEPSIN IS PRESCRIBED WITH GREATER ADVANTAGE.

A SPECIFIC IN VOMITING OF PREGNANCY.

IN DOSES OF 10 TO 20 GRAINS.

Opinions from Physicians Respecting its Efficacy.

INGLUVIN in SPAIN.—The following letter on Ingluvin was recently received by Vilanova, Hermanas & Co., of Barcelona, from DR. F. VIDAL SOLARES:—

"I have to acknowledge duly having received the Ingluvin which you were good enough to send me for the purpose of proving the therapeutic effects of this excellent medicine amongst my clients, from Messrs Wm. R. Warner & Co.

The results which I have obtained in my dispensary for sick children, together with my private cases, have been extremely satisfactory. In fact, I have treated various cases of dyspepsia, in which the patients, fully prostrated and without power to digest their food, have, thanks to the use of Ingluvin, been rapidly cured.

In the case of 'apepsia,' or loss of appetite, in children, accompanied with diarrhœa, I have obtained good results from the use of Ingluvin, which therapeutic agent is extracted by the house of Warner & Co., from the stomach of the chicken.

I have found Ingluvin useful in the organic complaints of the stomach, and in the indomitable vomiting and painful dyspepsia to which women are subject during pregnancy. I have employed the agent, moreover, in the convalescent state of many patients, when I have not only noted the alteration of the gastric secretions, but of the extreme instability of the stomach,

I have not the least doubt that the Ingluvin, of which you have the sale in Spain, will in a short time become a substitute for pepsin on account of its being more active than the latter; but, as is only logical, you should obtain a rapid result by bringing this preparation to be known in all Spain by the opportune measure you usually adopt.

Hoping you will have the justice to manifest to the manufacturer the results I have obtained in my practice with Ingluvin, I am,

Respectfully, F. VIDAL SOLARES, M. D.

A SPECIFIC IN VOMITING IN PREGNANCY.

Drugs and Digestion.—The discussion of a paper with this title, read by Dr. R. G. ECCLES at a previous meeting (see vol. xliv, page 600), was now taken up.

Dr. P. H KRETZSCHMAR said that he had made some investigations of the same subject several years before, and had arrived at some of the reader's conclusions.

Dr. ARNOLD STUB fully coincided with Dr. Kretzschmar as to the value of the Pharmacopœia as a guide both for apothecaries and for physicians. He knew little of Ingluvin, and less of what became of it after it entered the stomach, but he had prescribed it for the vomiting of pregnancy, and it had checked it after everything else had failed; consequently, he should continue to use it in such cases, and perhaps in those cases only. *New York Medical Journal.*

MESSRS WM. R. WARNER & Co. London, W., November 29th, 1 89.

Gentlemen:—I have tried your Ingluvin in a case of vomiting in pregnancy with the greatest success, and I have found it altogether a very useful preparation.

yours faithfully, ARTHUR H. WOOD, L.R.C.P., L.R.C.S.L.F.P.S.

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PEACOCK'S BROMIDES

(SYR: BROM: COMP: PEACOCK.)

Each fluid drachm represents 15 grains of the Combined C. P. Bromides of Potassium, Sodium, Calcium, Ammonium and Lithium.

Uses: Epilepsy, Uterine Congestion, Headache, and all Congestive, Convulsive and Reflex Neuroses.

This preparation produces results which can not be obtained from the use of commercial Bromide substitutes.

DOSE.—One to two FLUID drachms, in WATER, three or more times a day.

CHIONIA FROM CHIONANTHUS

Uses: Biliousness, Jaundice, Dyspepsia, Constipation, and all Diseases Caused by Hepatic Torpor.

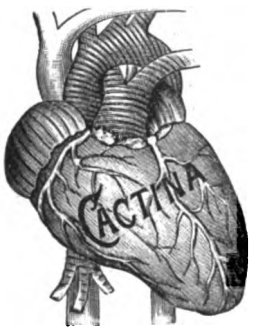
CHIONIA stimulates the Liver and restores it to a healthy condition, without debilitating the system by Catharsis; does not purge, per se, but under its use the Liver and Bowels gradually resume their normal functions

DOSE.—One Fluid Drachm three times a day.

SAMPLES SENT TO ANY PHYSICIAN WHO WILL PAY EXPRESS CHARGES.

PEACOCK CHEMICAL CO., - ST. LOUIS.

CACTINA PILLETS



Indicated in abnormal heart action, mental depression, and general debility.

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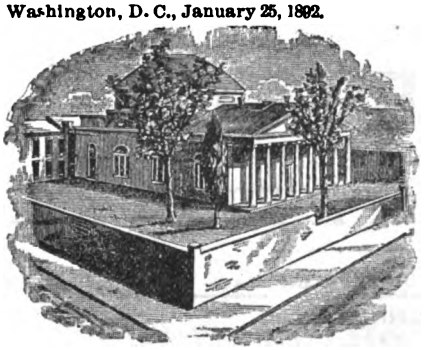
Several years ago, however, I began to treat such cases with Buffalo Lithia Water, with a result that was as astonishing to me as it was beneficial to the patient, so that now in all cases of nervous diseases under my charge in which there is an excess of uric acid in the blood, I use the Buffalo Lithia Water in large quantities. By this I mean that I do not have the patient drink merely a tumbler or two in the course of the day, but that I flood him, so to speak, with the water, making him drink a gallon, or even more, in the twenty-four hours. By this course the urine after a few days ceases to deposit uric acid crystals on standing, the morbid irritability of the patient disappears, the tongue becomes clean, the wandering pains in the head are abolished, and the system is rendered much more amenable to the special treatment which may be necessary for the cure of the disease from which the patient suffers.

I have tried carbonate of lithia dissolved in water in various proportions, but it certainly does not, in cases to which I refer, have the same effect as Buffalo Lithia Water.

Washington, D. C., January 25, 1892.



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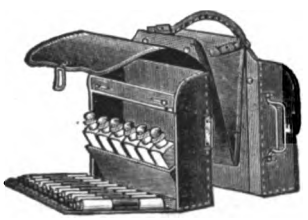

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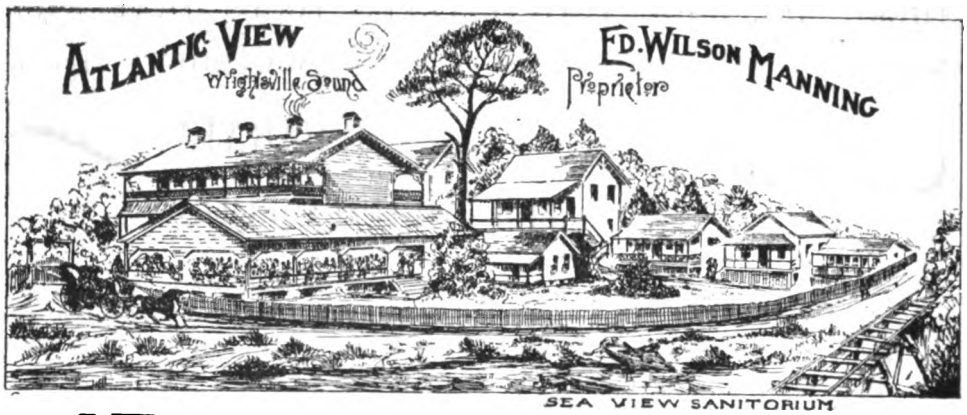

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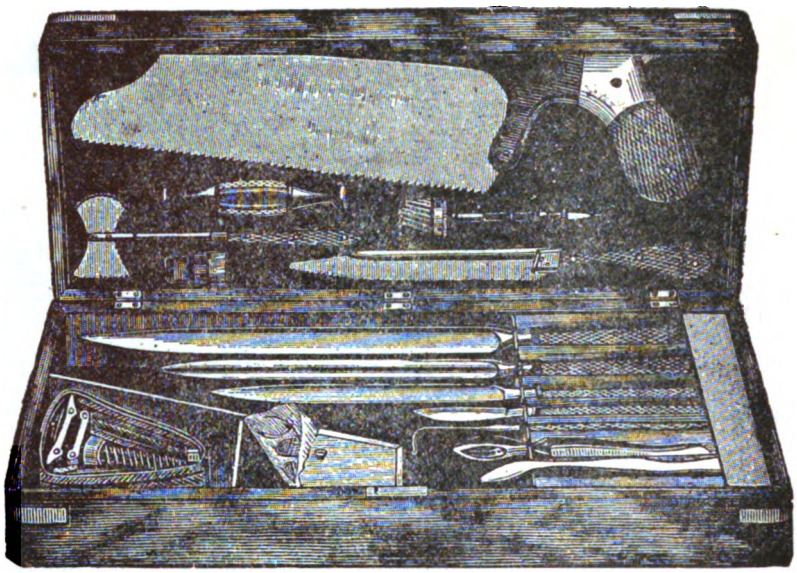

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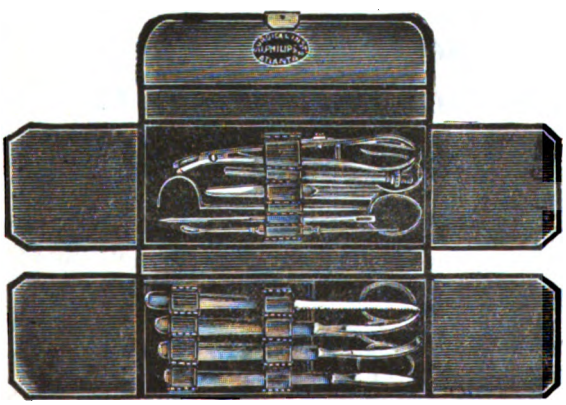

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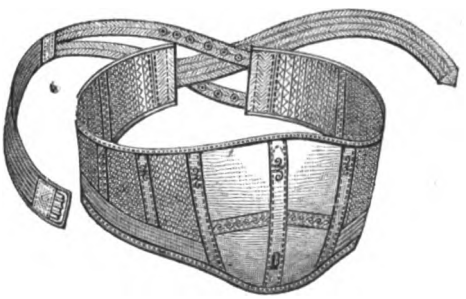

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REFERENCE:—W. F. Waugh, A. M., M. D., late prof. to the Medico-Chirurgical College, Philadelphia; also Editor of the Medical *Times and Register*. Address, 1725 Arch Street, Philadelphia, Pa. Also Dr. Richard Lund, in active practice thirty years, of Albuquerque, New Mexico, who has adopted the Mineral Treatment after a six weeks personal investigation in Washington, D. C.

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Fig. XIII—Sim's Position

Fig. VII—Horizontal Position—Elevated.

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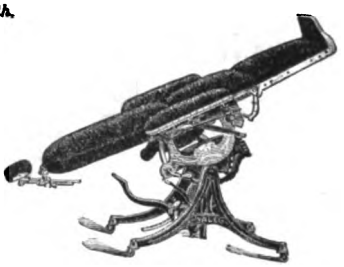

Fig. IX—Chloroform Narcosis Position

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Fig. XVII—Dorsal Position.

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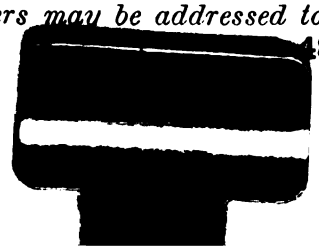

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